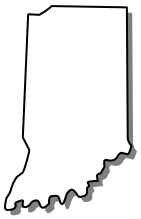
DA Home and Community-Based Services Waiver Program



INDIANA HEALTH COVERAGE PROGRAMS

Division of Aging

# Home and Community-Based Services Waiver Provider Manual

LIBRARY REFERENCE NUMBER: PRPR10013
PUBLISHED:JUNE 2013
POLICIES AND PROCEDURES AS OF JANUARY 1, 2013
VERSION 1.0

Library Reference Number: PRPR10013

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# *Revision History*

| Version | Date | Reason for Revision | Completed by |
|---|---|---|---|
| 1.0 | Policies and Procedures as of January 1, 2013<br>Published: June 10, 2013 | Initial Release | FSSA |

# *Table of Contents*

# *Section 1: Introduction*

## Overview

*Section 1915(c)* of the *Social Security Act* permits states to offer, under a waiver of statutory requirements, an array of Home and Community-Based Services (HCBS) that an individual needs to avoid institutionalization. These programs allow the state of Indiana's Medicaid program to provide services that would ordinarily be provided only in an institution to be provided in an individual's home or other community setting. Individuals must qualify for institutional care to be eligible for home and community-based services. The term waiver refers to waiving of certain federal requirements that otherwise apply to Medicaid program services. For example, home and community-based services or "waivers" are not Medicaid entitlement programs. .

The Office of Medicaid Policy and Planning (OMPP) has overall responsibility for the waiver programs; day-to-day administration and operation of individual waiver programs may be delegated to other divisions within the Family and Social Services Administration. The Division of Aging (DA) offers two waiver programs, the Aged & Disabled (A&D) waiver and the Traumatic Brain Injury (TBI) waiver.

The purpose of this manual is to provide a primary reference for the A&D and TBI waiver providers. The manual provides instruction to case managers, other service providers, state staff, family members, advocates, and waiver participants and is available to assist all those who administer, manage, and participate in the A&D and TBI waiver programs. The information and direction in this manual replaces all previous waiver manuals. Current waiver requirements can be found in the approved waiver applications and the Aging Rule *455 IAC 2*.

Individuals and their families may find additional information in the Indiana Medicaid HCBS Waiver Guide for Consumers courtesy of the Indiana Governor's Planning Council for People with Disabilities at http://www.in.gov/gpcpd.

## Indiana Health Coverage Programs Waiver Provider Responsibilities

### *IHCP Provider Agreement*

Waiver providers are enrolled in the Indiana Health Coverage Programs (IHCP) and have executed an *IHCP Provider Agreement* with the Indiana Family and Social Services Administration (FSSA). This agreement states that the provider will comply, on a continuing basis, with all the federal and state statutes and regulations pertaining to the IHCP, including the waiver programs' rules and regulations. Forms are available on the Forms page of indianamedicaid.com. By signing the agreement, the provider agrees to follow the information provided in the *IHCP Provider Manual*, as amended periodically, and the *Division of Aging Home and Community-Based Services Waiver Provider Manual*, as amended periodically, as well as all provider bulletins and notices. All amendments to the *IHCP Provider Manual*, the *Division of Aging Home and Community-Based Services Waiver Provider Manual*, and all applicable Indiana Administrative Codes (IACs), Rules, and Regulations are binding on publication. The *Division of Aging Home and Community-Based Services Waiver Provider Manual* and all publications are available online on the Manuals page of indianamedicaid.com.

### *Provider Record Updates*

To ensure timely communication of all information, providers must notify the FSSA and its fiscal agent when enrollment record information changes. Provider information is stored in two systems, Indiana*AIM* and INsite. Indiana*AIM* is maintained by the fiscal agent and INsite is maintained by FSSA.

Indiana*AIM* is the Medicaid Management Information System (MMIS). The fiscal agent is responsible for maintaining Indiana*AIM*; therefore, the fiscal agent must have accurate pay to, mail to, and service location information on file for all providers. It is the provider's responsibility to ensure that the information on file with the fiscal agent is correct. Providers are required to submit address and telephone change information to the fiscal agent within 10 days of any change. If the provider is licensed through the Indiana State Department of Health, the provider must also notify the Indiana State Department of Health of any changes to the provider's name, address, or telephone number. Forms are available on the Forms page of indianamedicaid.com.

INsite is the system that stores client eligibility information along with the client's service plans, notice of actions (NOAs), Level of Care (LOC) information, and case notes entered by the case managers for individual clients. INsite also has a provider database that is maintained by Medicaid waiver provider relations specialist and is intended to provide up-to-date information to the field about the certification status of waiver providers. Provider selection profiles (pick lists) are generated from INsite; therefore, it is very important that the information listed in INsite is the most current and up-to-date information available. Provider information changes must be made by contacting the waiver provider relations specialist at the Division of Aging.

## Provider Responsibilities Specific to the Waiver Program

Providers must understand the service definitions and parameters for each service authorized on the NOA. All waiver providers are subject to audit and potential recoupment if the services provided are not in agreement with the services authorized as indicated on the approved NOA. If the needs of a waiver participant change, the provider must contact the case manager to discuss revising the service plan.

If a service requires prior authorization (PA) through the State Plan, it is the provider's responsibility to obtain an appropriate PA denial before filing a claim for HCBS services. An appropriate PA denial must be related to the actual service and not related to the PA process. For example, a PA denial with the reason, *provider did not submit required documentation*, would not be considered an appropriate PA denial.

### *Waiver Provider Application and Certification*

**Becoming a waiver provider begins with the FSSA certification "approval" process and is finalized with the IHCP provider enrollment process. The Division of Aging must certify providers of the Aged & Disabled and Traumatic Brain Injury waivers. Applicants must complete both the certification process through the Division of Aging and the IHCP enrollment process through the fiscal intermediary (HP).**

- A prospective provider may request an application packet from the Division of Aging (DA). An information and application packet (with accompanying attachments) will be sent to the prospective provider either through U.S. mail or email.
- Application packets may be requested from and returned to the DA waiver provider relations specialist:

  **Waiver Provider Relations Specialist**
  **Division of Aging / MS 21**

**402 West Washington Street, Room W454**
**Indianapolis, Indiana 46204-2243**

- When a completed application is received, it is date stamped and reviewed by the waiver provider relations specialist.
- If additional information is needed, a letter will be sent to the prospective provider with a request for additional information. A 30-day timeframe is given for submission of additional information.
- If information is sufficient and meets the requirements for specific services, the provider is certified for the requested services.
- Preliminary information is entered into the waiver provider database and the waiver provider relations specialist sends the provider a Waiver Service Certification Letter.
- The cover letter directs the provider to contact the fiscal intermediary (HP) to complete the IHCP provider enrollment process. The applicant is instructed to attach a copy of the DA waiver certification to the IHCP application for processing.

## *Waiver Provider Enrollment*

Once a prospective provider receives the DA *Waiver Service Certification Letter,* the enrollment process with the IHCP begins. **The enrollment application MUST be submitted within 90 days of certification.**

- A prospective provider may obtain an Indiana Health Coverage Programs (IHCP) Provider Enrollment Application by downloading it from the Provider Enrollment page on indianamedicaid.com, or by contacting 1-877-707-5750 to request an application by mail.
- Prospective providers must complete the enrollment application form and submit the completed application form along with the *Waiver Service Certification Letter* to the following address:

  **Provider Enrollment**
  **P.O. Box 7263**
  **Indianapolis, IN 46207-7263**

### Helpful Tips for Completing the IHCP Enrollment Application

The application form asks that you choose a business structure. As a waiver provider, you are enrolled as either a sole practitioner (billing provider), or a group (a group must have members linked to the group), the members linked to the group are called rendering providers and are enrolled as rendering providers linked to the group. Rendering providers cannot bill for services; the group bills for services, identifying the rendering provider as the performer of the service. To be a group with members, all of the members must be certified by the Division of Aging.

Each prospective provider must designate a "type" and "specialty." The IHCP provider type for HCBS waiver providers is 32 (Waiver). The specialties you choose must be the ones you are certified by the Division of Aging provider relations specialist to provide:

- 350 – Aged & Disabled Waiver (AD)
- 356 – Traumatic Brain Injury (TBI)

The enrollment application must be signed and submitted with the requested documentation, including form W-9; electronic funds transfer (EFT) form; and a copy of the *Waiver Service Certification Letter*.

All enrollment forms must be directed to the Provider Enrollment address listed previously (address is also listed on the application form) to ensure proper processing.

Enrollment documents are logged into a document tracking system and issued a document tracking number.

Provider Enrollment has a dedicated staff member assigned to coordinate and handle all waiver provider enrollments and updates. This staff member works closely with the DA provider relations waiver specialist to ensure timely and accurate maintenance of waiver files.

The staff member reviews the enrollment packet to ensure completeness according to the Provider Enrollment guidelines and enter the provider's information into Indiana*AIM*. A provider letter is generated and sent to the provider detailing the assigned IHCP provider billing number and enrollment information entered into Indiana*AIM*. Providers are encouraged to review this letter to ensure enrollment accuracy.

If the enrollment documents are incomplete, the entire enrollment packet is returned to the provider with a letter that provides an explanation of the incomplete information. The provider is required to complete the documentation and return the entire packet to Provider Enrollment.

## Waiver Provider Information Updates

Updates for the following information must be submitted to the Division of Aging waiver provider relations specialist:

- Name changes
- Tax identification changes
- Additional service locations (additional service location addresses)
  - Requires new DA Waiver Service Certification
- Specialty changes (all specialties must be certified by the FSSA)
  - Requires new DA Waiver Service Certification
- Changes in ownership (CHOW)
  - Requires new DA Waiver Service Certification

Once update certification requirements have been met for the provider, the Division of Aging waiver provider relations specialist sends a new *Waiver Service Certification Letter* to the provider detailing the approved services and instructing the provider to begin the update process with the IHCP. The IHCP Provider Enrollment staff member works closely with the DA provider relations specialist to complete and maintain provider enrollment information**.**

Providers are required to obtain an IHCP Provider Enrollment Update Form on the Provider Enrollment page at indianamedicaid.com or by contacting the Provider Enrollment helpline at 1-877-707-5750 to request the update form. Providers must complete the update form with appropriate signature, and submit the form along with the waiver certification letter to the following address:

**Provider Enrollment**
**P.O. Box 7263**
**Indianapolis, IN 46207-7263**

Updates for the following information must be submitted to the IHCP Provider Enrollment Unit:

- Name changes
- Tax Identification Changes
- Additional Service Locations (additional Service Location Addresses)
  - Requires a copy of the new DA Waiver Service Certification Letter
- Specialty changes (all specialties must be certified by the FSSA)
  - Requires a copy of the new DA Waiver Service Certification Letter
- Changes in ownership (CHOW)
  - Requires a copy of the new DA Waiver Service Certification Letter

The IHCP Provider Enrollment analyst reviews the update form and documents to ensure completeness according to the Provider Enrollment guidelines, and updates the provider's information in Indiana*AIM*. An automated provider letter is generated, detailing the changes made to the enrollment record. Providers are encouraged to review this letter to ensure enrollment accuracy.

All questions regarding the status of the waiver provider's enrollment or updates can be directed to the Provider Enrollment helpline at 1-877-707-5750.

# *Section 2: Claims and Billing*

## Overview

The Office of Medicaid Policy and Planning (OMPP) has overall responsibility for the waiver programs; day-to-day administration and operation of individual waiver programs may be delegated to other divisions within the Family and Social Services Administration

## Eligibility for HCBS Waiver Services Affects Billing

All potential waiver members must enroll in the IHCP. At this time, waiver participants may not be enrolled in managed care. To be eligible for reimbursement for waiver services, the waiver member must have an open waiver level of care status in Indiana*AIM*. All service providers must verify IHCP eligibility for each member before initiating services.

The Area Agencies on Aging (AAA) are the entry points for the Aged & Disabled waivers and Traumatic Brain Injury waivers. Initial eligibility (level of care) is determined at the entry point agencies. Before the level of care is recorded in Indiana*AIM*, the level of care and the initial service plan must be approved and a start date established. The level of care segment with the start date is then entered into Indiana*AIM* by the Division of Aging (DA).

| | |
|---|---|
| *Note:* | *The fiscal agent cannot add or correct a waiver level of care segment in IndianaAIM nor terminate a managed care enrollment.* |

## Waiver Authorization

The waiver case manager is responsible for completing the service plan, which results in an approved Notice of Action (NOA). The NOA details the services and number of units to be provided, the name of the authorized provider, and the approved billing code with the appropriate modifiers. The case manager transmits this information to the waiver database (INsite). INsite communicates this data to Indiana*AIM*, where it is stored in the prior authorization database. Claims deny if no authorization exists in the database or if a code other than the approved code is billed. Providers are not to render or bill services without an approved NOA. It is the provider's responsibility to contact the case manager if there is any discrepancy in the services authorized or rendered and the approved NOA.

## Billing Instructions

HCBS waiver claims are billed on the paper *CMS-1500* claim form or via the 837P electronic transaction. Web interChange is an interactive web application that allows providers to access Indiana*AIM* through the Internet. Web interChange is fast, free, and does not require special software. To submit a Medicaid waiver claim on the *CMS-1500* claim form, the boxes listed in Table 1 on the claim form must be completed. Table 1 on the claim form provides an explanation of each box. Please refer to the most current provider bulletin that contains the *CMS-1500* claim form information, which is available on the Bulletins page of indianamedicaid.com.

Providers bill services based on an approved NOA, using an appropriate procedure code and the pricing method associated with the procedure code, such as per unit, per day, or per month. Additional

pricing information is available on the Fee Schedule on indianamedicaid.com. General guidelines include:

- Do not bill for services before they are provided.
- If a unit of service equals 15 minutes, a minimum of eight minutes must be provided to bill for one unit.
- Activities requiring less than eight minutes may be accrued to the end of that date of service.
- At the end of the day, partial units may be rounded as follows: units totaling eight or more minutes may be rounded up and billed as one unit.
- Partial units totaling less than eight minutes may not be billed.
- Monthly units are billed at the end of the month.
- Daily units may be billed daily, weekly, or monthly.

> *Note: If a waiver member is temporarily in an institutional setting, a provider may not render nor be reimbursed for waiver services during that time. Claim Tips and Reminders*

When billing Medicaid waiver claims, the provider must consider the following:

- The IHCP does not reimburse time spent by office staff billing claims.
- Providers may bill only for those services authorized on an approved NOA.
- A claim should include dates of service within the same month. Do not submit a claim with dates that span across more than one month on the same claim.
- The units of service as billed to the IHCP must be substantiated by documentation in accordance with the appropriate Indiana Administrative Code (IAC) regulations and the waiver documentation standards issued by the OMPP and Division of Aging (DA).
- Services billed to the IHCP must meet the service definitions and parameters as published in the aforementioned rules and standards.
- Updated information is disseminated through IHCP provider bulletins posted on indianamedicaid.com and DA bulletins (sent via email and posted on the state agency websites). Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices.

Refer to the *IHCP Provider Manual* for instructions on how to complete the paper *CMS-1500* claim form. In addition, the fiscal agent and the OMPP recommend submitting claims electronically. Providers may submit claims electronically using Web interChange. For information about Web interChange, please refer to indianamedicaid.com or contact provider assistance. Phone numbers are available on the IHCP Provider Quick Reference, which is available on the Contact Us page of indianamedicaid.com.

## Claim Voids and Replacements

If a paid or denied claim must be adjusted (replaced), the initial claim is voided and a new claim takes the place of the old claim. If the claim was paid before the adjustment was made, any money paid is recouped by setting up an account receivable (AR) for the amount of the recoupment, which is identified on the remittance advice (RA).

The *CMS-1500* adjustment form is available on the Forms page of indianamedicaid.com. Instructions for completing the form are located in the *IHCP Provider Manual*.

# Division of Aging HCBS Waiver Rates

This section identifies procedure codes and modifiers, the waivers that the service is available for, and the payment methodology associated with the procedure code.

Figure 2.1 − Division of Aging HCBS Waiver Rates as of January 1, 2013

| Insite code | Division of Aging Rate Schedule | Price Code | Mod 1 | Mod 2 | Mod 3 | Dsc Proc Modified | A & D | TBI | Notes |
|---|---|---|---|---|---|---|---|---|---|
| | ADULT DAY SERVICE TRANSPORTATION | T2003 | U7 | | | U7=WAIVER | $17.83 | $17.06 | Per Trip |
| AL1 | ASSIST LIVING WAIVER/DIEM | T2031 | U7 | U1 | | U7=WAIVER; U1=LEVEL1 | $66.55 | N/A | Day |
| AL2 | ASSIST LIVING WAIVER/DIEM | T2031 | U7 | U2 | | U7=WAIVER; U2=LEVEL2 | $73.33 | N/A | Day |
| AL3 | ASSIST LIVING WAIVER/DIEM | T2031 | U7 | U3 | | U7=WAIVER; U3=LEVEL3 | $80.33 | N/A | Day |
| ATTC | ATTENDANT CARE SERVICES (Agency) | S5125 | U7 | UA | | U7=WAIVER; UA=PROVIDER (AGENCY) | $4.70 | $3.99 | .25 Hour |
| ATTC | ATTENDANT CARE SERVICES (Consumer Directed) | S5125 | U7 | U1 | | U7 = WAIVER U1= ATTC FI | $2.70 | N/A | .25 Hour |
| ATTC | ATTENDANT CARE SERVICES (NonAgency) | S5125 | U7 | | | U7=WAIVER | $2.85 | $2.44 | .25 Hour |
| BMAN | BEHAVIORAL HEALTH COUNSEL | H0004 | U7 | U1 | | U7= WAIVER U1= LEVEL 1 | N/A | $17.38 | .25 Hour |
| BMAN | BEHAVIORAL HEALTH COUNSEL | H0004 | U7 | U2 | | U7 = WAIVER U2 = LEVEL 2 | N/A | $17.38 | .25 Hour |
| CMGT | CASE MANAGEMENT | T1016 | U7 | | | U7=WAIVER | $11.34 | $100.00 | A&D .25 Hour TBI per month |
| CMGT | CASE MANAGEMENT, PER MNTH (Health Care | T2022 | U7 | U1 | | U7=WAIVER; U1=LEVEL1 Health Care Coordination | $48.06 | $48.06 | Monthly Rate |
| ADS1 | DAY SERVICES, ADULT | S5100 | U7 | U1 | | U7=WAIVER; U1=LEVEL1 | $3.00 | $3.00 | .25 Hour |
| ADS2 | DAY SERVICES, ADULT | S5100 | U7 | U2 | | U7=WAIVER; U2=LEVEL2 | $3.00 | $3.00 | .25 Hour |
| ADS3 | DAY SERVICES, ADULT | S5100 | U7 | U3 | | U7=WAIVER; U3=LEVEL3 | $3.00 | $3.00 | .25 Hour |
| PRSI | EMERGENCY RESPONSE SYSTEM | S5160 | U7 | | | U7=WAIVER | $54.41 | $52.07 | Install |
| PRSM | EMERGENCY RESPONSE SYSTEM | S5161 | U7 | | | U7=WAIVER | $54.41 | $52.07 | Monthly Rate |
| AF1 | FOSTER CARE, ADULT; | S5141 | U7 | U1 | | U7=WAIVER; U1=LEVEL1 | $57.48 | $57.48 | Day |
| AF2 | FOSTER CARE, ADULT; | S5141 | U7 | U2 | | U7=WAIVER; U2=LEVEL2 | $67.33 | $67.33 | Day |
| AF3 | FOSTER CARE, ADULT; | S5141 | U7 | U3 | | U7=WAIVER; U3=LEVEL3 | $78.38 | $78.38 | Day |
| HDM | HOME DELIVERED MEALS, INC | S5170 | U7 | | | U7=WAIVER | $5.32 | $5.32 | Per Meal |
| EMOI | HOME MODIFICATION INSTALL | S5165 | U7 | NU | | U7=WAIVER; NU=NEW DME | $15,000.00 | $15,000.00 | Life Cap |
| EMOM | HOME MODIFICATION MAINTENANCE | S5165 | U7 | RP | | U7=WAIVER; RP=REPLACEMENT AND REPAIR | $500.00 | $500.00 | Annual Cap |
| HMK | HOMEMAKER SERVICE, NOS (Agency) | S5130 | U7 | UA | | U7=WAIVER; UA=PROVIDER | $3.71 | $3.15 | .25 Hour |
| HMK | HOMEMAKER SERVICE, NOS (NonAgency) | S5130 | U7 | | | U7=WAIVER | $2.70 | $2.29 | .25 Hour |
| NUTS | NUTRITIONAL SUPPLEMENT | B4150 | U7 | | | U7=WAIVER (Annual Cap) | $1,200.00 | $1,200.00 | Annual Cap |
| RBHA | RESIDENTIAL BASED REHABILITATION | 97535 | U7 | | | U7=WAIVER | N/A | $6.99 | .25 Hour |
| RNUR | RESPITE CARE SERVICES | T1005 | U7 | UA | TD | U7=WAIVER; UA=PROVIDER; TD=RN | $3.74 | $7.79 | .25 Hour |
| RNUR | RESPITE CARE SERVICES | T1005 | U7 | UA | TE | U7=WAIVER, UA=PROVIDER, TE=LPN | $6.70 | $5.91 | .25 Hour |
| ATCH | SPECIALIZED MEDICAL EQUIP | T2029 | U7 | NU | | U7=WAIVER; NU=NEW DME | $50,000.00 | $50,000.00 | No Cap, $50k is Manual Review |
| ATCM | SPECIALIZED MEDICAL EQUIP | T2029 | U7 | RP | | U7=WAIVER; RP=REPLACEMENT AND REPAIR | $500.00 | $500.00 | Annual Cap |
| DAY HAB | STRUCTURED DAY PROGRAM- GROUP | T2021 | U7 | HQ | | U7=WAIVER; HQ=GROUP SETTING | N/A | $1.67 | .25 Hour |
| DAY HAB | STRUCTURED DAY PROGRAM- INDIVIDUAL | T2021 | U7 | | | U7=WAIVER | N/A | $8.38 | .25 Hour |
| HSE | SUPPORTED EMPLOY | H2023 | U7 | | | U7=WAIVER | N/A | $3.17 | .25 Hour |
| RHHA | UNSKILLED RESPITE CARE, N | S5150 | U7 | UA | U9 | U7=WAIVER; UA=PROVIDER; U9=HOME HEALTH AIDE | $5.02 | $4.00 | .25 Hour |
| VMOD | VEHICLE MODIFICATIONS | T2039 | U7 | | | U7=WAIVER | $15,000.00 | $15,000.00 | Life Cap |
| PEST | PEST CONTROL | T2025 | U7 | U1 | | U7=WAIVER; U1=PEST CONTROL | $600.00 | $600.00 | Annual Cap |

# *Section 3: Quality Assurance/Quality Improvement*

## Quality Monitoring

The Division of Aging (DA) is responsible for monitoring compliance with the provider and case management standards for the waivers administered by DA as detailed in *455 IAC.* Noncompliance with the standards may result in corrective action plans or other sanctions, up to and including termination as a waiver provider.

The purpose of the Division of Aging Quality Assurance and Quality Improvement Unit is to protect the safety and well-being of individuals by monitoring and ensuring the integrity and cost-effectiveness of programs administered by the Division of Aging.
The role of the DA QA/QI unit is to:

- Monitor all providers who are not licensed by the Indiana State Department of Health
- Assure services to all participants are delivered in accordance with the participant's service plan, the specifications identified in the approved waiver and *455 IAC.*
- Collect and analyze information and data in order to implement sound remediation of problems at the individual, organization, and systemic levels.
- Participate with other stakeholders in the development of policies and procedures that all providers, including case managers, must follow to assure compliance with Indiana Administrative Codes and CMS assurances, and to protect participants' health and welfare.

The components of the DA Quality Assurance and Quality Improvement (QA/QI) program are:

- Incident reporting
- Complaint resolution
- Mortality review
- Coordination with Adult Protective Services (APS) and the local Area Agencies on Aging (AAAs) and case managers
- Quality reviews (provider compliance surveys, participant-centered compliance surveys, participant experience surveys)
- Coordination with Medicaid Surveillance and Utilization Review (SUR) and the Indiana State Department of Health (ISDH)
- Implementation of Quality Improvement Strategy (QIS) process

## Incident Reporting

**Providers with first knowledge of a reportable event are required to report that event via the designated website at: https://ddrsprovider.fssa.in.gov/IFUR/.**

Incidents are defined as unusual occurrences affecting the health and safety of HCBS participants, including death. Incidents are required to be reported within 48 hours of knowledge of the event, or within 24 hours of knowledge if the incident involves suspicion or evidence of abuse, neglect, exploitation or death. Providers are required to send a copy of all incident reports to the participant's case manager. Incidents involving suspicion or evidence of abuse, neglect, exploitation, or death must also be reported to Adult Protective Services (APS) or Child Protective Services (CPS), as applicable.

Each provider of services must establish and make available to the participant a written procedure for reporting incidents to DA.

Reportable incidents include, but are not limited to:

- Alleged, suspected, reported, or observed abuse or battery, neglect, or exploitation of a participant. **The provider is required to suspend staff alleged to have committed abuse, neglect, or exploitation from direct-care responsibilities, pending the outcome of the provider's investigation.**
- The death of a participant
- Significant injury to the participant requiring medical intervention
- Any suicidal ideation, threat, or attempt of suicide made by the participant
- Any hospitalization due to a significant change in health or mental status
  - Any medical event which represents a life-threatening or life-altering event needs to be reported. Examples: heart attack, stroke
- Participant elopement or missing person
- Inadequate formal or informal support for a participant, including inadequate supervision, which endangers the participant
- Medication error occurring in a 24/7 or day program setting
- A residence that compromises the health and safety of a participant, including pest infestations which represent a potential of source of harm.
- Suspected or observed criminal activity by staff, a family member, or a participant receiving services, or the participant receiving services
- Police arrest of the participant or any person responsible for the care of the participant
- A major disturbance or threat to public safety created by the participant
- Any use of restraint on the participant, including but not limited to, physical, mechanical, and pharmaceutical

Providers are required to report incidents regardless of whether they were providing services at the time of the incident. All provider staff should be familiar with incident reporting requirements and procedures, as knowledge of an incident occurs when any employee of the provider becomes aware of the event. If a provider or case manager has confirmed with another provider that an incident has already been reported, an additional report is not required, but the provider may wish to file an additional report to relay additional information or another perspective of the event.

The Division of Aging or its agent reviews, codes, and determines the level of follow-up required to an incident. Additional information may be requested from the provider or case manager. When formal follow-up is required, the case manager is required to submit follow-up reports via the web-based incident reporting system every seven days until the Division of Aging closes the report.

## Complaint Resolution

The DA addresses complaints submitted by or on behalf of any individual receiving services through a waiver administered by the Division of Aging. Complaints may be initiated by any individual through the IR system, mail, phone, or fax. Complaint investigations may result in findings requiring remediation. Provider failure to complete remediation may result in sanctions up to and including termination as a waiver provider.

## Mortality Review

As part of its QA/QI process, the Division of Aging reviews all waiver consumer deaths to identify service delivery failures or opportunities for improvement at the provider and system level. Providers may be asked to submit case notes, service delivery records, or other pertinent information or records for review. The Mortality Review Committee (MRC) may refer waiver providers, case managers, or nonwaiver service providers to the relevant regulatory body, including law enforcement, for additional action. The MRC may also refer complaints against a waiver provider or case manager for internal remediation through the complaint resolution process.

## Quality Reviews

The Division of Aging has contracted with a quality assurance organization to administer Provider Compliance Reviews, Person Centered Compliance Reviews, and Participant Experience Surveys. Provider Compliance Reviews and Person Centered Compliance Reviews will entail an extensive review of provider and case manager documentation, service delivery records, policies and procedures and compliance with other waiver and state requirements. Findings of one or more deficiencies relating to provider standards will result in a remediation process to correct the deficiencies. Provider failure to cooperate with the review procedure or to complete the remediation process will result in a referral to the DA Quality Assurance/Quality Improvement (QA/QI) Unit as a formal complaint, which may result in sanctions up to and including termination as a waiver provider.

## QIS Process

The Division of Aging QA/QI Unit aggregates and analyzes data from all waiver processes to identify incidents of noncompliance with waiver requirements and opportunities to achieve more positive outcomes. Findings are reviewed for viable remediation options. Provider failure to complete required remediation may result in sanctions up to and including termination as a waiver provider.

The QA/QI Unit, working in conjunction with the OMPP and the QA/QI Committee, recommends systemic improvements and assesses the performance of the QA/QI components.

# Section 4: Financial Oversight

## Waiver Audits

The state of Indiana employs a hybrid program integrity (PI) approach to oversight of the waiver programs, incorporating oversight and coordination by a dedicated waiver specialist position within the Surveillance and Utilization Review (SUR) Unit, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) contractor arrangements. The Office of Medicaid Policy and Planning (OMPP) has expanded its PI activities using a multifaceted approach to SUR activity that includes provider self-audits, desk audits, and on-site audits. The FADS team analyzes claims data, allowing them to identify providers and claims that indicate aberrant billing patterns or other risk factors.

The PI audit process uses data mining, research, identification of outliers, problematic billing patterns, aberrant providers, and issues that are referred by other divisions and State agencies. In 2011, the State of Indiana formed a Benefit Integrity Team comprised of key stakeholders that meets biweekly to review and approve audit plans, provider communications and make policy and system recommendations to affected program areas. The SUR Unit also meets with all waiver divisions on a quarterly basis, at a minimum, and receives referrals on an ongoing basis to maintain open lines of communication and aid in understanding specific areas of concern such as policy clarification.

The SUR waiver specialist is a subject-matter expert (SME) responsible for directly coordinating with the various waiver divisions. This specialist also analyzes data to identify potential areas of program risk and identify providers that appear to be outliers warranting review. The SME may also perform desk or on-site audits and be directly involved in review of waiver providers and programs.

The OMPP maintains oversight throughout the entire PI process. While the FADS contractor may be incorporated in the audit process, no audit is performed without the authorization of OMPP. The OMPP's oversight of the contractor's aggregate data is used to identify common problems to be audited, determine benchmarks, and offer data to peer providers for educational purposes, when appropriate.

The SUR Unit offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with federal and State guidelines, including all Indiana Health Coverage Programs (IHCP) and waiver requirements. Detailed information on SUR policy and procedures is available in *Chapter 13* of the *IHCP Provider Manual* on indianamedicaid.com.

## FSSA Audit Oversight

The Audit Division of the FSSA reviews waiver audit team schedules and findings to reduce redundancy and assure use of consistent methodology.

## Medicaid Fraud Control Audit Overview

The Indiana Medicaid Fraud Control Unit (MFCU) is an investigative branch of the Attorney General's Office. MFCU conducts investigations in the following areas:

- Medicaid provider fraud
- Misuse of Medicaid members' funds

- Patient abuse or neglect in Medicaid facilities

When the MFCU identifies a provider that has violated one of these areas, the provider's case is presented to the state or federal prosecutors for appropriate action. Access information about MFCU at in.gov/attorneygeneral.gov.

# Section 5: Division of Aging Waivers

## Overview

Indiana administers two home and community-based waivers for persons who meet eligibility for nursing facility services:

- Waiver for persons who are Aged & Disabled
- Waiver for persons with a traumatic brain injury

Per agreement with the State Medicaid agency, the DA has responsibility for the day-to-day operations of these waivers, according to the approved waiver documents. The State Medicaid agency retains oversight authority.

## Level of Care (LOC)

Persons who meet eligibility for the Aged & Disabled Waiver must meet nursing facility (NF) *level of care*. The criteria necessary to meet this level of care is outlined in *405 IAC 1-3*. View the most up-to-date version of *405 IAC 1-3* in its entirety on the Internet at in.gov/legislative/iac/. Persons who meet eligibility for the Traumatic Brain Injury Waiver must meet either nursing facility level of care or intermediate care facility for individuals with intellectual disabilities (ICF/IID, formerly ICF/MR) level of care.

## Waivers

### *Aged & Disabled Waiver (A&D)*

#### Purpose

The Aged & Disabled Waiver is designed to provide an alternative to nursing facility admission for Medicaid-eligible persons over the age of 65, and persons of all ages with disabilities by providing supports to complement and supplement informal supports for persons who would require care in a nursing facility if waiver services or other supports were not available. Indiana's 16 Area Agencies on Aging act as the entry points for this waiver. The services available through this waiver are designed to help participants remain in their own homes, as well as to assist individuals residing in nursing facilities to return to community settings, such as their own homes, apartments, assisted living, or adult family care.

- Participant eligibility
  - Individuals meeting nursing facility LOC and Medicaid eligibility requirements must also meet at least one of the following criteria to receive services through this waiver:
    - Age 65 and older
    - Disabled
  - Entry to the waiver may be delayed due to the existence of a waiting list.
  - Priority admittance to the waiver may be made based on criteria outlined in the approved waiver.
- Medicaid aid categories
  - Aged (MAA)

  - Blind (MAB)
  - Low-income family (MAC)
  - Disabled (MAD)
  - Working disabled (MADW)
  - Children receiving Adoption Assistance or children receiving Federal Foster Care Payments under *Title IV E – Sec. 1902(a)(10)(A)(i)(I)* of the Act
  - Children receiving Adoption Assistance under a state adoption agreement- *Sec 1902(a)(10)(A)(ii)(VIII)*
  - Independent foster care adolescents – *Sec 1902(a)(10)(A)(ii)(XVII)*
  - Children under age 1 – Sec 1902(a)(10)(A)(i)(IV)
  - Children age 1 through 5 – *Sec 1902(a)(10)(A)(i)(VI)*
  - Children age 1 through 18 – *Sec 1902(a)(10)(A)(i)(VII)*
  - Transitional medical assistance – *Sec 1925* of the Act
- Services available: (Refer to *Section 7* for service definitions)
  - Adult day services
  - Adult family care
  - Assisted living
  - Attendant care
  - Case management
  - Community transition
  - Environmental modification
  - Health care coordination
  - Home-delivered meals
  - Homemaker
  - Nutritional supplements
  - Personal emergency response system
  - Pest control
  - Respite care
  - Specialized medical equipment and supplies
  - Transportation
  - Vehicle modification

## *Traumatic Brain Injury Waiver (TBI)*

### Purpose

The Traumatic Brain Injury Waiver provides home and community-based services to individuals who, but for the provision of such services, would require institutional care.

Indiana defines a traumatic brain injury as a trauma that has occurred as a closed or open head injury by an external event that results in damage to brain tissue, with or without injury to other body organs. Examples of external agents are: mechanical; or events that result in interference with vital functions. Traumatic brain injury means a sudden insult or damage to brain function, not of a degenerative or congenital nature. The insult or damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional, or physical functioning resulting in partial or total disability not including birth trauma related injury.

- Participant eligibility
  - Waiver participants must meet the minimal LOC requirements for that of a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID, formerly ICF/MR) and have a diagnosis of traumatic brain injury.
  - Entry to the waiver may be delayed due to the existence of a waiting list.

  - Priority admittance to the waiver may be made based on criteria outlined in the approved waiver.

- Medicaid aid category
  - Aged (MAA)
  - Blind (MAB)
  - Low-income family (MAC)
  - Disabled (MAD)
  - Working disabled (MADW)
  - Children receiving Adoption Assistance or children receiving Federal Foster Care Payments under *Title IV E – Sec 1902(a)(10)(A)(i)(I)* of the Act
  - Children receiving Adoption Assistance under a state adoption agreement – *Sec 1902(a)(10)(A)(ii)(VIII)*
  - Independent foster care adolescents – *Sec 1902(a)(10)(A)(ii)(XVII)*
  - Children under age 1 – *Sec 1902(a)(10)(A)(i)(IV*)
  - Children age 1 through 5 – *Sec 1902(a)(10)(A)(i)(VI)*
  - Children age 1 through 18 – *Sec 1902(a)(10)(A)(i)(VII)*
  - Transitional medical assistance – *Sec 1925* of the Act
  -

- Services available**:** (Refer to *Section 7* for service definitions)
  - Adult day services
  - Adult family care
  - Assisted living
  - Attendant care
  - Behavior management/behavior program and counseling
  - Case management
  - Community transition
  - Structured day program
  - Environmental modification
  - Healthcare coordination
  - Home-delivered meals
  - Homemaker
  - Nutritional supplements.
  - Personal emergency response system
  - Pest control
  - Residential-based habilitation
  - Respite
  - Specialized medical equipment and supplies
  - Structured-day program
  - Supported employment
  - Transportation
  - Vehicle modification

# *Section 6: Case Management*

## For Aged & Disabled and Traumatic Brain Injury Waivers

Medicaid waiver case managers coordinate and integrate all services required in a client's service plan, link clients to needed services and ensure that clients continue to receive and benefit from services. Waiver case managers enable clients to receive a full range of services needed due to a medical condition, in a planned, coordinated, efficient, effective manner.

Case management is a comprehensive service comprised of specific tasks and activities designed to coordinate and integrate all other services required in the client's service plan.

The components of case management are:

- Initial level of care (LOC) assessment
- Development of service plans including coordination of formal and informal supports
- Implementation of the service plan
- Assessment and care planning for discharge from institutionalization
- Bi-annual and ongoing reassessments of LOC
- Quarterly assessment of individual's needs, per 90- Day Review tool
- Periodic updates of care plans
- Monitoring the quality of home care community services
- Determining and monitoring the cost effectiveness of the provisions of home and community-based services
- Information and assistance services
- Enhancement or termination of services based on need
- Administrative guidance
- Participation in Medicaid Fair Hearing process.

Case management services for persons on the nursing facility Medicaid waivers are provided by certified case managers, as approved by the Division of Aging (DA). The 16 local Area Agencies on Aging (AAA) serve as the single point of entry for the nursing facility Medicaid waivers. A case manager from the AAA is assigned to an applicant. After an applicant has been determined to meet the eligibility criteria and approved to receive nursing facility Medicaid waiver services, he or she may choose to retain his or her current AAA case manager or choose a non-AAA or independent case manager, for ongoing case management services.

Minimum qualifications for case managers are the following:

- All case management services provided must comply with the case management standards.
- The minimum educational and experience criteria for providing this service under the A&D and TBI waivers are:
  - A Qualified Mental Retardation Professional (QMRP) who meets the QMRP requirements at *42 CFR 483.430*
  - A registered nurse with one year's experience in human services; or
  - A Bachelor's degree in Social Work, Psychology, Sociology, Counseling, Gerontology, or Nursing; or Health & Human Services; or
  - A Bachelor's degree in any field with a minimum of two years' full-time, direct service experience with the elderly or disabled (including assessment, care plan development, and monitoring); or

  - A Master's degree in a related field may substitute for the required experience
- All case managers must attend the Division of Aging Case *Management Orientation* before providing waiver case management services. Until a case manager has successfully completed the orientation, he or she may not work independently.
- All case managers must annually obtain at least 20 hours of training regarding case management services. Ten hours of this training must be training approved by the DA under the nursing facility waiver program.

If the DA identifies a systemic problem with a case manager's services, the case manager must obtain training on the topics recommended by the DA

Case management may not be conducted by any organization, entity, or individual that also delivers other in-home and community-based services under the Division of Aging waiver programs, or any organization, entity, or individual related by common ownership or control to any other organization, entity, or individual that also delivers other in-home and community-based services under the nursing facility waiver program, unless the organization is an AAA that has been granted permission by the Family and Social Services Administration to provide direct services to clients.

- *Common Ownership* exists when an individual, individuals, or any legal entity possesses ownership or equity of at least 5% in the provider, as well as the institution or organization serving the provider. *Control* exists where an individual or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised.
- *Related* means associated or affiliated with, or having the ability to control, or be controlled by.

Reimbursement of case management services, as defined in this manual, may not be made unless and until the client becomes eligible for waiver service. Case management service provided to individuals who are not eligible for Division of Aging waiver services will not be reimbursed as a waiver service.

## Case Management Monitoring Standards

The *On-going Medicaid Home and Community Based Services Waiver Case Management Standards* is the document that delineates the standards each nursing facility waiver case manager must meet to fulfill the Family and Social Services Administration (FSSA) DA guiding principles of responsive, efficient, effective, quality, and timely service delivery; effective communication; respect, dignity, integrity, and rights for all individuals; person-centered planning, informed choice, and personal empowerment; community-based services; fiscal stewardship; and quality customer services.

Case managers are to comply with all applicable DA standards. The following section is excerpted from the *Case Management Medicaid Waiver Provider Agreement*.

### *Ongoing Medicaid Home and Community Based Services Waiver Case Management Standards*

1. Case managers will maintain the highest professional and ethical standards in the conduct of their business.
2. Case managers will comply with all DA issued manuals, as well as all federal, state, and local law, and all FSSA policy, rules, regulations and guidelines, including the *Health Insurance Portability and Accountability Act* (HIPAA).
3. New case managers will complete case manager orientation as approved by the DA prior to being eligible for Medicaid reimbursement.

4. Case managers will maintain competency by completing 20 hours of DA-approved training in each calendar year. The training will include 10 hours of DA-approved core training and 10 hours of related training per calendar year. Required training hours are prorated in a case manager's first year and are in addition to new case manager orientation.
5. Individuals will choose their service provider, including case manager, and have the right to change any provider, including case manager.
6. Case managers will provide individuals a list of potential providers, furnished by the state of Indiana, including case managers and the services offered by each provider.
7. Case managers will provide, at a minimum but not limited to, a state information guide to individuals on how to choose a provider and will assist the individual to evaluate potential service providers.
8. A maximum response time between implementation of the initial service plan and the first monitoring contact will be no more than 30 calendar days.
9. Case managers will have face-to-face contact with each individual a minimum of every 90 days to assess the quality and effectiveness of the service plan. At least two of these face-to-face contacts per year will be in the home setting.
10. Case managers will document, in the chronological narrative, each contact with the individual and each contact with providers within seven days of activity.
11. Case manager documentation **must** show activity relevant to the service plan to be reimbursed.
12. Case managers will facilitate and monitor the formal and informal supports that are developed to maintain the individual's health and welfare in the community.
13. Case managers will provide each individual or guardian with clear and easy instructions for contacting the case manager or case manager agency. The case manager will also provide additional information and procedures for individuals who may need assistance or have an emergency that occurs before or after business hours. This information will be located in the home in a location that is visible from the telephone.
14. Case managers will complete face-to-face Annual Assessments and update the service plan as needed, in collaboration with the individual, in a timely and appropriate manner to avoid gaps in service authorization, including assuring that the individual or guardian receives instructions on how to request an appeal through the Medicaid Fair Hearing process.
15. Case managers will communicate the individual's needs, strengths, and preferences to the support team.
16. Case managers will ensure that person centered planning is occurring on an ongoing basis.
17. Case managers will monitor the ongoing services to ensure that they reflect the service plan, including the individual's medication regime.
18. Case managers will base the service plan upon the individual's needs, strengths, and preferences.
19. Case managers will ensure that the individual and all providers have a current, comprehensive service plan that meets the needs of the individual.
20. Case managers will review and explain to the individual or guardian the services that will be provided, and the individual or their designated representative will sign the service plan to show understanding of and agreement with the plan.
21. Case managers will ensure that the individual or guardian, providers, and involved agencies have a copy of relevant documentation, as specified in the *Waiver Case Management Manual*, including instructions on how to request an appeal.

22. Case managers will obtain all required signatures on the service plan before submitting it to the State. The service plan will not be implemented prior to receiving state approval.
23. Case managers will document the quality; timeliness; and appropriateness of care, services, and products delivered by providers.
24. Case managers will initiate timely follow-up of identified problems, whether self-identified or referred by others. Critical or crisis issues, including incident reports, will be acted upon immediately, as specified by the DA. All follow-up and resolution will be documented in the individual record.
25. Case managers will comply with all automation standards and requirements as prescribed by the DA for documentation and processing of case management activities.
26. Case managers will comply with all automation standards and requirements as prescribed by the DA for documentation and processing of case management activities.
27. Case managers will maintain privacy and confidentiality of all individual records. No information will be released or shared with others without the individual or guardian's written consent.
28. Case managers will provide to the State upon request, ready access to all case manager documentation, either electronic or hard copy.
29. Case manager documentation will demonstrate that the safety and welfare of the individual are being monitored on a regular basis.

# Section 7: Service Definitions

## Service Definition Overview

This section of the manual lists service definitions for the services currently approved for the Home and Community-Based Waiver Services (HCBS) Nursing Facility Level of Care Waiver program. Each service definition includes the following information:

- Service Definition
- Allowable Activities
- Service standards
- Documentation standards
- Limitations
- Activities not allowed
- Provider qualifications
  - A Provider Qualifications table identifies the waiver, the license or certification requirements, and any additional standards that apply.

A table containing procedure (billing) codes and modifiers as well as unit rates is found in Figure 2.1.

## Adult Day Services

### *Service Definition*

Adult Day Services (ADS) are community-based group programs designed to meet the needs of adults with impairments through individual service plan. These structured, comprehensive, nonresidential programs provide health, social, recreational, and therapeutic activities, supervision, support services, and personal care. Meals or nutritious snacks are required. The meals cannot constitute the full daily nutritional regimen. However, each meal must meet one-third of the daily Recommended Dietary Allowance. These services must be provided in a congregate, protective setting.

Participants attend ADS on a planned basis. The three levels of ADS are Basic, Enhanced, and Intensive. The ADS Assessment tool may be obtained from the Waiver provider relations specialist. The assessment should be conducted with the individual being served, their family, the case manager and the provider when possible.

### *Allowable Activities*

Basic Adult Day Services (Level 1) includes:

- Monitoring or supervising all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed
- Comprehensive, therapeutic activities
- Health assessment and intermittent monitoring of health status
- Monitoring medication or medication administration
- Appropriate structure and supervision for those with mild cognitive impairment
- Minimum staff ratio: One staff for each eight individuals

Enhanced Adult Day Services (Level 2) includes Level 1 service requirements must be met. Additional services include:

- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care
- Health assessment with regular monitoring or intervention with health status
- Dispensing or supervising the dispensing of medication to individuals
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers
- Therapeutic structure, supervision, and intervention for those with mild to moderate cognitive impairments
- Minimum staff ratio: One staff for each six individuals

Intensive Adult Day Services (Level 3) includes Level 1 and Level 2 service requirements must be met. Additional services include:

- Hands-on assistance or supervision with all ADLs and personal care
- One or more direct health interventions required
- Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy coordinated or available
- Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care
- Therapeutic interventions for those with moderate to severe cognitive impairments
- Minimum staff ratio: One staff for each four individuals

## Service Standards

Adult Day Services must follow a written service plan addressing specific needs determined by the client's assessment

## Documentation Standards

- Services outlined in the service plan
- Evidence that level of service provided is required by the individual
- Attendance record documenting the date of service and the number of units of service delivered that day
- Completed Adult Day Service Level of Service Evaluation form. Case manager must give the completed Adult Day Service Level of Service Evaluation form to the provider.

## Limitations

Adult Day Services are allowed for a maximum of 10 hours per day.

## Activities Not Allowed

- Any activity that is not described in allowable activities
- Services to participants receiving Assisted Living waiver service

> *Note: Therapies provided through this service will not duplicate therapies provided under any other service.*

## Provider Qualifications

Table 7.1 – Provider Qualifications Table for Adult Day Service

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | FSSA/DA approved Adult Day Service Provider | Not required | DA approved<br>*455 IAC 2* Provider Qualifications: Becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider Qualifications: General requirements<br>*455 IAC 2* Provider Qualifications: General requirements for direct care staff<br>*455 IAC 2* Procedures for Protecting Individuals<br>*455 IAC 2* Unusual occurrence; reporting<br>*455 IAC 2* Transfer of individual's record upon change of provider<br>*455 IAC 2* Notice of termination of services<br>*455 IAC 2* Provider organizational chart<br>*455 IAC 2* Collaboration and quality control<br>*455 IAC 2* Data collection and reporting standards<br>*455 IAC 2* Quality assurance and quality improvement system<br>*455 IAC 2* Financial information<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Maintenance of personnel records<br>*455 IAC 2* Adoption of personnel policies<br>*455 IAC 2* Operations manual<br>*455 IAC 2* Maintenance of records of services provided<br>*455 IAC 2* Individual's personal file; site of service delivery<br>*455 IAC 2* Maintenance of records of services provided<br>*455 IAC 2* Individual's personal file; site of service delivery |

# Adult Family Care

## Service Definition

Adult Family Care (AFC) is a comprehensive service in which a participant resides with an unrelated caregiver for the participant to receive personal assistance designed to provide options for alternative long-term care to individuals who meet nursing facility level of care and whose needs can be met in a home-like environment. The participant and up to three other participants who are elderly or have physical and/or cognitive disabilities who are not members of the provider's or primary caregiver's family, reside in a home that is owned, rented, or managed by the AFC provider.

The goal of the service is to provide necessary care while emphasizing the participant's independence. This goal is reached through a cooperative relationship between the participant (or the participant's legal guardian), the participant's HCBS Medicaid Waiver case manager, and the AFC provider. Participant needs shall be addressed in a manner that support and enable the individual to maximize abilities to function at the highest level of independence possible. The service is designed to provide options for alternative long-term care to persons who meet Nursing Facility level of care, and whose needs can be met in an AFC setting.

Another goal is to preserve the dignity, self-respect, and privacy of the participant by ensuring high quality care in a non-institutional setting. Care is to be furnished in a way that fosters the independence of each participant to facilitate aging in place in a home environment that will provide the participant with a range of care options as the needs of the participant change.

Participants selecting AFC service may also receive Case Management service, Adult Day Service, Specialized Medical Equipment and Supplies, and Health Care Coordination through the waiver.

> *Note: The provider shall provide the recipients room-and-board rates that are no higher than the Social Security Income (SSI) rate current at the time room-and-board services are provided, less the amount of the personal needs allowance for room and board for Medicaid eligible individuals. The individual is entitled to retain his or her full Personal Needs Allowance (PNA $52.00) out of his or her income, even if it means the facility does not receive the entire amount of the SSI maximum budget. The Adult Family Care Medicaid per diem can be used to satisfy the monthly spend-down.*

## Allowable Activities

The following are included in the daily *per diem* for AFC:

- Attendant care
- Chores
- Companion services
- Homemaker
- Medication oversight (to the extent permitted under State law)
- Personal care and services
- Transportation for necessary appointments that include transporting individuals to doctor appointments and community activities that are therapeutic in nature or assists with maintaining natural supports
- Consumer-focused activities that are appropriate to the needs, preferences, age, and condition of the individual participant

- Assistance with correspondence and bill paying if requested by participant

## *Service Standards*

- AFC Services must follow a written service plan addressing specific needs determined by the individual's assessment.
- Services must address the participant's level of service needs.
- Provider must live in the AFC home, unless another provider-contracted primary caregiver, who meets all provider qualifications, lives in the provider's home.
- Backup services must be provided by a qualified individual familiar with the individual's needs for those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of care.
- AFC provides an environment that has the qualities of a home, including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences.
- Rules managing or organizing the home activities in the AFC home that are developed by the provider or provider-contracted primary caregiver, or both and approved by the Medicaid waiver program must be provided to the individual prior to the start of AFC services and may not be so restrictive as to interfere with a participant's rights under state and federal law.
- Consumer-focused activity plans are developed by the provider with the participant or their representative.
- AFC emphasizes the participant's independence in a setting that protects and encourages participant dignity, choice and decision-making while preserving self-respect.
- Providers or provider's employees who provide medication oversight as addressed under allowed activities must receive necessary instruction from a doctor, nurse, or pharmacist on the administration of controlled substances prescribed to the participant.

## *Documentation Standards*

- Identified need in the service plan
- Services outlined in the service plan
- Completed *Adult Family Care Level of Service Evaluation* form required
- The completed *Adult Family Care Level of Service Evaluation* form given to the provider by the case manager
- Daily documentation to support services rendered by the AFC to address needs identified in the *Adult Family Care Level of Service Evaluation* form
  - Participant's status
  - Updates
  - Participation in consumer-focused activities
  - Medication management records, if applicable
- Documentation of the consumer-focused activities participation maintained in the personal file
- Maintenance of participant's personal records to include:
  - Social Security number
  - Medical insurance number
  - Birth date
  - All medical information available including all prescription and nonprescription drug medication currently in use
  - Most recent prior residence
  - Hospital preference
  - Mortuary (if known)
  - Religious affiliation and place of worship, if applicable
- Participant's personal records must contain copies of all applicable documents:

- Advance directive
- Living will
- Power of attorney
- Healthcare representative
- Do not resuscitate (DNR) order
- Letters of guardianship

> *Note: If applicable, copies must be:*
> *• Placed in a prominent place in the consumer file*
> *• Sent with the consumer when transferred for medical care*

## Activities Not Allowed

- Services provided in the home of a caregiver who is related by blood or related legally to the participant
- Adult family care services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the healthcare representative (HCR) of a participant, or the legal guardian of a participant
- Payments for room and board or the costs of facility maintenance, upkeep, or improvement
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional

The Adult Family Care service *per diem* does not include room and board.

Separate payment will not be made for Homemaker, Respite, Environmental Modifications, Vehicle Modifications, Transportation, Personal Emergency Response System, Attendant Care, Assisted Living, Home Delivered Meals, Nutritional Supplements, Pest Control, and Community Transition Services furnished to a participant selecting Adult Family Care Services as these activities are integral to and inherent in the provision of Adult Family Care Services.

## Provider Qualifications

Table 7.2 – Provider Qualifications Table for Adult Family Care

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | FSSA/DA approved Adult Family Care Individual | Not required | Provider and home must meet the requirements of the Indiana Adult Family Care Service Provision and Certification Standards. Adult Family Care service providers are required to be bonded.<br><br>DA approval based upon provider compliance with 455 IAC 2<br><br>DA approved<br>*455 IAC 2* Becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider Qualifications; General requirements<br>*455 IAC 2* General requirements for direct care staff<br>*455 IAC 2* Procedures for protecting individuals<br>*455 IAC 2* Unusual occurrence; reporting<br>*455 IAC 2* Transfer of individual's record upon change of provider |

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| | | | *455 IAC 2* Notice of termination of services<br>*455 IAC 2* Provider organizational chart<br>*455 IAC 2* Collaboration and quality control<br>*455 IAC 2* Data collection and reporting standards<br>*455 IAC 2* Quality assurance and quality improvement system<br>*455 IAC 2* Financial information<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Transportation of an individual<br>*455 IAC 2* Documentation of qualifications<br>*455 IAC 2* Maintenance of personnel records<br>*455 IAC 2* Adoption of personnel policies<br>*455 IAC 2* Operations manual<br>*455 IAC 2* Maintenance of records of services provided<br>*455 IAC 2* Individual's personal file; site of service delivery |
| A&D, TBI | FSSA/DA approved Adult Family Care Agency | Not required | Provider and home must meet the requirements of the Indiana Adult Family Care Service Provision and Certification<br>DA approval base upon provider compliance with *455 IAC 2* and *455 IAC 3*<br><br>DA approved<br>*455 IAC 2* Becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider Qualifications: General Requirements<br>*455 IAC 2* General requirements for direct care staff<br>*455 IAC 2* Procedures for protecting individuals<br>*455 IAC 2* Unusual occurrence; reporting<br>*455 IAC 2* Transfer of individual's record upon change of provider<br>*455 IAC 2* Notice of termination of services<br>*455 IAC 2* Provider organizational chart<br>*455 IAC 2* Collaboration and quality control<br>*455 IAC 2* Data collection and reporting standards<br>*455 IAC 2* Quality assurance and quality improvement system<br>*455 IAC 2* Financial information<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Transportation of an individual<br>*455 IAC 2* Documentation of qualifications<br>*455 IAC 2* Maintenance of personnel records<br>*455 IAC 2* Adoption of personnel policies<br>*455 IAC 2* Operations manual<br>*455 IAC 2* Maintenance of records of services provided<br>*455 IAC 2* Individual's personal file; site of service delivery |

# Assisted Living

## *Service Definition*

Assisted living service is defined as personal care and services, homemaker, chore, attendant care and companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a residential facility which is licensed by the Indiana State Department of Health (ISDH), in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Individuals reside in their own living units (which may include dually occupied units when both occupants request the arrangement) which include kitchenette, toilet facilities, and a sleeping area, not necessarily designated as a separate bedroom from the living area. The individual has a right to privacy. Living units may be locked at the discretion of the individual, except when a physician or mental health professional has certified in writing that the individual is sufficiently impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity centers, which may also serve as living rooms or dining rooms. The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be individual-driven to the maximum extent possible, and treat each person with dignity and respect.

Participants selecting Assisted Living service may also receive Case Management service, Specialized Medical Equipment and Supplies, and Community Transition services through the waiver.

> *Note: The provider shall provide the recipients room- and-board rates that are no higher than the SSI rate current at the time room-and-board services are provided, less the amount of the personal needs allowance for room and board for Medicaid eligible individuals. The individual is entitled to retain his or her full Personal Needs Allowance (PNA $52.00) out of his or her income, even if it means the facility does not receive the entire amount of the SSI maximum budget. The Assisted Living Medicaid per diem can be used to satisfy the monthly spend-down.*

## *Allowable Activities*

The following are included in the daily *per diem* for Assisted Living Services:

- Attendant care
- Chores
- Companion services
- Homemaker
- Medication oversight (to the extent permitted under State law)
- Personal care and services
- Therapeutic social and recreational programming

### *Service Standards*

- Assisted Living services must follow a written service plan (POC) addressing specific needs determined by the client's assessment.

### *Documentation Standards*

- Services outlined in the service plan
- Evidence that individual requires the level of service provided
- Documentation to support service rendered
- Negotiated risk agreement, if applicable
- Completed *Assisted Living Level of Service Evaluation* form required
- The completed *Adult Family Care Level of Service Evaluation* form given to the provider by the case manager

### *Activities Not Allowed*

- The Assisted Living service *per diem* does not include room and board
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional

Separate payment will not be made for Homemaker, Respite, Environmental Modifications, Vehicle Modifications, Transportation, Personal Emergency Response System, Attendant Care, Adult Family Care, Adult Day Services, Home Delivered Meals, Nutritional Supplements, Pest Control, and Community Transition Services furnished to a participant selecting Assisted Living Services as these activities are integral to and inherent in the provision of the Assisted Living Service.

### *Provider Qualifications*

Table 7.3 – Provider Qualifications Table for Assisted Living

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D | Licensed Assisted Living Agencies | *IC 16-28-2* | DA approved<br>*410 IAC 16.2-5* |

## Attendant Care

### *Service Definition*

Attendant care services primarily involve hands-on assistance for aging adults and persons with disabilities. These services are provided to allow aging adults or persons with disabilities to remain in their own homes and to carry out functions of daily living, self-care, and mobility.

### *Allowable Activities*

Homemaker activities that are essential to the individual's healthcare needs to prevent or postpone institutionalization when provided during the provision of other Attendant Care Services are allowed:

- Provides assistance with personal care which includes:
  - Bathing, partial bathing
  - Oral hygiene
  - Hair care including clipping of hair

  - Shaving
  - Hand and foot care
  - Intact skin care
  - Application of cosmetics
- Provides assistance with mobility which includes:
  - Proper body mechanics
  - Transfers
  - Ambulation
  - Use of assistive devices
- Provides assistance with elimination which includes:
  - Assists with bedpan, bedside commode, toilet
  - Incontinent or involuntary care
  - Emptying urine collection and colostomy bags
- Provides assistance with nutrition which includes:
  - Meal planning, preparation, clean-up
- Provides assistance with safety which includes:
  - Use of the principles of health and safety in relation to self and individual
  - Identify and eliminate safety hazards
  - Practice health protection and cleanliness by appropriate techniques of hand washing
  - Waste disposal, and household tasks
  - Reminds individual to self-administer medications
  - Provides assistance with correspondence and bill paying
  - Escorts individuals to community activities that are therapeutic in nature or that assist with developing and maintaining natural supports

## Service Standards

- Attendant care services must follow a written service plan addressing specific needs determined by the individual's assessment
- If direct care or supervision of care is not provided to the client and the documentation of services rendered for the units billed reflects homemaker duties, an entry must be made to indicate why the direct care was not provided for that day. If direct care or supervision of care is not provided for more than 30 days and the documentation of services rendered for the units billed reflects homemaker duties, the case manager must be contacted to amend the service plan to a) add Homemaker Services and eliminate Attendant Care Services or b) reduce attendant care hours and replace with the appropriate number of hours of homemaker services

## Documentation Standards

- Need must be identified in the service plan.
- Services must be outlined in the service plan.
- Data record of services must be provided, including:
  - Complete date and time of service (in and out)
  - Specific services or tasks provided
  - Signature of employee providing the service (minimally the last name and first initial)
    - If the person providing the service is required to be a professional, the title of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.
- Documentation of service delivery is to be signed by the participant or designated participant representative.

## *Activities Not Allowed*

- Attendant Care services will not be provided to medically unstable individuals as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional
- Attendant Care services will not be provided to household members other than to the participant
- Attendant Care services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant
- Attendant Care services to participants receiving Adult Family Care waiver service, Structured Family Caregiving waiver service, or Assisted Living waiver service

## *Provider Qualifications*

Table 7.4 – Provider Qualifications Table for Attendant Care

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | Licensed Home Health Agency | *IC 16-27-1*<br>*IC 16-27-4* | DA approved |
| A&D, TBI | Licensed Personal Services Agency | *IC 16-27-4* | DA approved |
| A&D, TBI | FSSA/DA approved Attendant Care Individual | *IC 16-27-4* | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Provider Qualifications; General requirements<br>*455 IAC 2* General requirements for direct care staff<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements<br>*455 IAC 2* Personnel Records<br><br>The division may reject any applicant with a conviction of a crime against persons or property, a conviction for fraud or abuse in any federal, state, or local government program, (42 USC §1320a-7) or a conviction for illegal drug possession. The division may reject an applicant convicted of the use, manufacture, or distribution of illegal drugs (42 USC §1320a-7). The division may reject an applicant who lacks the character and fitness to render services to the dependent population or whose criminal background check shows that the applicant may pose a danger to the dependent population. The division may limit an applicant with a criminal background to caring for a family member only if the family member has been informed of the criminal background. |

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| | | | Compliance with *IC 16-27-4*, if applicable. |

# Behavior Management/Behavior Program and Counseling

## *Service Definition*

Behavior Management includes training, supervision, or assistance in appropriate expression of emotions and desires, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors.

Behavior plans must be developed, monitored, and amended by a master's level Psychologist or a master's in Special Education, supervised by an individual with a Ph.D. in Behavioral Science. Persons providing Behavior Management/Behavior Program and Counseling who are employed by a qualified agency must be a Master's level behaviorist, or a Certified Brain Injury Specialist (CBIS), or a Qualified Mental Retardation Professional (QMRP), or a Certified Social Worker who is supervised by a Master's level behaviorist. An individual practitioner providing this service must be a Master's level behaviorist.

## *Allowable Activities*

- Observation of the individual and environment for purposes of development of a plan and to determine baseline
- Development of a behavioral support plan and subsequent revisions
- Training in assertiveness
- Training in stress reduction techniques
- Training in the acquisition of socially accepted behaviors
- Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavior support plan
- Consultation with members
- Consultation with health service provider in psychology (HSPP)

## *Service Standards*

- Behavior Management/Behavior Program and Counseling services must follow a written service plan addressing specific needs determined by the individual's assessment
- The behavior specialist will observe the individual in his/her own environment and develop a specific plan to address identified issues.
- The efficacy of the plan must be reviewed not less than quarterly and adjusted as necessary.
- The behavior specialist will provide a written report to pertinent parties at least quarterly. "Pertinent parties" includes the individual, guardian, waiver case manager, all service providers, and other involved entities.

## *Documentation Standards*

- Identified need in the service plan
- Services outlined in the service plan
- Service plan must have the identified level clinician
- Behavioral support plan
- Data record of clinician service documenting the date and time of service, and the number of units of service delivered that day with the service type

## *Activities Not Allowed*

- Aversive techniques
- Any techniques not approved by the individual's person centered planning team and the Division of Aging
- Behavior Management/Behavior Program and Counseling services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant

## *Provider Qualifications*

Table 7.5 – Provider Qualifications Table for Behavior Management/ Behavior Program and Counseling

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| TBI | FSSA/DA approved Behavior Management/ Behavior Program and Counseling Individual | Not required | DA approval based upon provider compliance with 455 IAC 2<br><br>DA approved<br>*455 IAC 2* Provider Qualifications; General requirements<br>*455 IAC 2* General requirements for direct care staff<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements<br>*455 IAC 2* Personnel Records<br>An individual practitioner providing this service must be a Master's level behaviorist. |
| TBI | FSSA/DA approved Behavior Management/ Behavioral Program and Counseling Agency | Not required | DA approval based upon provider compliance with *455 IAC 2*<br>DA approved<br>*455 IAC 2* Provider Qualifications; General requirements<br>*455 IAC 2* General requirements for direct care staff<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements<br>*455 IAC 2* Personnel Records |

# Case Management

## *Service Definition*

Case Management is a comprehensive service comprising a variety of specific tasks and activities designed to coordinate and integrate all other services required in the individual's service plan.

## *Allowable Activities*

- Assessments of eligible individuals to determine eligibility for services, functional impairment level, and corresponding in-home and community services needed by the individual
- Development of service plans to meet the individual's needs
- Implementation of the service plans, linking individual with needed services, regardless of the funding source
- Assessment and care planning for discharge from institutionalization
- Annual and quarterly face-to-face reassessments of individual's needs
- Periodic updates of care plans
- Monitoring of the quality of home care community services provided to the individual
- Determination of and monitoring the cost effectiveness of the provisions of in-home and community services
- Information and assistance services
- Enhancement or termination of services based on need
- Administrative guidance as described in Appendix E-1-j of the waiver application for those participants who have selected self-directed attendant care

## *Service Standards*

- Case Management Services must be reflected in the service plan of the individual.
- Services must address needs identified in the service plan.

## *Documentation Standards*

Documentation for Billing:

- Approved provider
- Must provide documentation identifying them as the case manager of record for the individual (the pick list is appropriate documentation)
- Must document all activities on behalf of individual being served within seven days of service

Clinical/Progress Documentation:

- Services must be outlined in the service plan.
- Evidence that individual requires the level of service must be provided.
- Documentation to support services rendered must be provided.
- Case manager must ensure that the LOC review form is sent to the participant/applicant within 10 working days of the issue date and must document in the electronic case management database system the date the LOC review form was delivered.

## Activities Not Allowed

- Case Management may not be conducted by any organization, entity, or individual that also delivers other in-home and community-based services, or by any organization, entity, or individual related by common ownership or control to any other organization, entity, or individual who also delivers other in-home and community-based services, unless the organization is an Area Agency on Aging that has been granted permission by the Family and Social Services Administration Division of Aging to provide direct services to individuals.

> *Note: Common ownership exists when an individual, individuals, or any legal entity possess ownership or equity of at least 5% in the provider as well as the institution or organization serving the provider. Control exists where an individual or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. Related means associated or affiliated with, or having the ability to control, or be controlled by.*

- Independent case managers and independent case management companies may not provide initial applications for Medicaid Waiver services.
- Reimbursement of case management under Medicaid Waivers may not be made unless and until the individual becomes eligible for Medicaid Waiver services. Case management provided to individuals who are not eligible for Medicaid Waiver services will not be reimbursed as a Medicaid Waiver service.
- Case management services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in fact (POA) of a participant, or the HCR of a participant, or the legal guardian of a participant..

## Provider Qualifications

Table 7.6 – Provider Qualifications Table for Case Management

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | FSSA/DA approved Case Management Individual | Not required | DA, or its designee, approved<br>*455 IAC 2* Documentation of qualifications<br>*455 IAC 2* Case Management<br>Liability Insurance<br><br>Education and work experience<br>• A qualified mental retardation professional (QMRP) who meets the QMRP requirements at *42 CFR 483.430*<br>• Meets one of the following requirements:<br>– A registered nurse with one year's experience in human services<br>– A bachelor's degree in social work, psychology, sociology, counseling, gerontology, or nursing; health and human services<br>– A bachelor's degree in any field with a minimum of two years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring)<br>– A master's degree in a related field may |

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| | | | substitute for the required experience |
| A&D, TBI | FSSA/DA approved Case Management Agency | Not required | DA, or its designee, approved<br>*455 IAC 2* Provider Qualifications; General requirements<br>*455 IAC 2* General requirements for direct care staff<br>*455 IAC 2* Procedures for protecting individuals<br>*455 IAC 2* Unusual occurrence; reporting<br>*455 IAC 2* Transfer of individual's record upon change of provider<br>*455 IAC 2* Notice of termination of services<br>*455 IAC 2* Provider organizational chart<br>*455 IAC 2* Collaboration and quality control<br>*455 IAC 2* Data collection and reporting standards<br>*455 IAC 2* Quality assurance and quality improvement system<br>*455 IAC 2* Financial information<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Documentation of qualifications<br>*455 IAC 2* Maintenance of personnel records<br>*455 IAC 2* Adoption of personnel policies<br>*455 IAC 2* Operations manual<br>*455 IAC 2* Maintenance of records of services provided<br>*455 IAC 2* Individual's personal file; site of service delivery<br>*455 IAC 2* Maintenance of records of services provided<br>*455 IAC 2* Individual's personal file; site of service delivery<br>*455 IAC 2* Case Management<br><br>Education and work experience<br>• A qualified mental retardation professional (QMRP) who meets the QMRP requirements at *42 CFR 483.430*<br>• Meets one of the following requirements:<br>– A registered nurse with one year's experience in human services<br>– A Bachelor's degree in social work, psychology, sociology, counseling, gerontology, or nursing<br>– A Bachelor's degree in any field with a minimum of two years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring)<br>– A Master's degree in a related field may substitute for the required experience |

# Community Transition

## Service Definition

Community Transition services include reasonable, setup expenses for individuals who make the transition from an institution to their own home where the person is directly responsible for his or her own living expenses in the community and will not be reimbursable on any subsequent move.

> *Note: "Own home" is defined for this service as any dwelling, including a house, an apartment, a condominium, a trailer, or other lodging that is owned, leased, or rented by the individual or the individual's guardian or family, or a home that is owned and/ or operated by the agency providing supports.*

Items purchased through Community Transition are the property of the individual receiving the service, and the individual takes the property with him or her in the event of a move to another residence, even if the residence from which he or she is moving is owned by a provider agency. Nursing Facilities are not reimbursed for Community Transition because those services are part of the *per diem*. For those receiving this service under the waiver, reimbursement for approved Community Transition expenditures are reimbursed through the local Area Agency on Aging (AAA).

## Allowable Activities

- Security deposits that are required to obtain a lease on an apartment or home
- Essential furnishings and moving expenses required to occupy and use a community domicile including a bed, table or chairs, window coverings, eating utensils, food preparation items, microwave, bed or bath linens
- Setup fees or deposits for utility or service access including telephone, electricity, heating, and water
- Health and safety assurances including pest eradication, allergen control, or one-time cleaning prior to occupancy

## Service Standards

Community Transition services must follow a written service plan addressing specific needs determined by the individual's assessment.

## Documentation Standards

- Identified need in the service plan
- Services outlined in the service plan
- Documentation requirements include maintaining receipts for all expenditures, showing the amount and what item or deposit was covered

## Limitations

Reimbursement for Community Transition is limited to a lifetime cap for setup expenses, up to $1,500.

## Activities Not Allowed

- Apartment or housing rental or mortgage expenses
- Food
- Appliances

- Diversional or recreational items such as hobby supplies
- Television
- Cable TV access
- VCRs
- Regular utility charges
- Services to participants receiving Adult Family Care waiver service
- Services to participants receiving Assisted Living waiver service

## *Provider Qualifications*

Table 7.7 – Provider Qualifications Table for Community Transition

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | FSSA/DA approved Community Transition Service Agency | Not required | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider qualifications: General requirements<br>*455 IAC 2* Transfer of individual's record upon change of provider<br>*455 IAC 2* Financial information<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Transportation of an individual<br>*455 IAC 2* Professional qualifications and requirements; documentation of qualifications<br>*455 IAC 2* Maintenance of personnel records<br>*455 IAC 2* Adoption of personnel policies<br>*455 IAC 2* Operations manual<br>*455 IAC 2* Maintenance of records of services provided<br>*455 IAC 2* Individual's personal file; site of service delivery |

# Environmental Modifications

## *Service Definition*

Environmental modifications are minor physical adaptations to the home, as required by the individual's service plan which are necessary to ensure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

### Home Ownership

Environmental modifications shall be approved for the individual's own home or family-owned home. Rented homes or apartments are allowed to be modified only when a signed agreement from the landlord is obtained. The signed agreement must be submitted along with all other required waiver documentation.

### Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is a strong written justification from the case manager detailing why a provider with a higher bid should be selected.

### Requirements

All environmental modifications must be approved by the waiver program prior to services being rendered.

- Environmental modification requests must be provided in accordance with applicable State or local building codes and should be guided by Americans with Disability Act (ADA) or ADA Accessibility Guidelines (ADAAG) requirements when in the best interest of the individual and his or her specific situation.
- Environmental modifications shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:
  - The modification is the most cost effective or conservative means to meet the individual's needs for accessibility within the home.
  - The environmental modification is individualized, specific, and consistent with, but not in excess of, the individual's needs.
- Requests for modifications at two or more locations may only be approved at the discretion of the Division of Aging director or designee.
- Requests for modifications may be denied if the State division director or State agency designee determines the documentation does not support residential stability and/or the service requested.

## *Allowable Activities*

Justification and documentation is required to demonstrate that the modification is necessary to meet the individual's identified needs.

- Adaptive door openers and locks − Limited to one per individual primary residence for an individual living alone or who is alone without a caregiver for substantial periods of time but has a need to open, close or lock the doors and cannot do so without special adaptation.
- Bathroom Modification − Limited to one existing bathroom per individual primary residence when no other accessible bathroom is available. The bathroom modification may include:

  - Removal of existing bathtub, toilet, or sink
  - Installation of roll in shower, grab bars, ADA toilet, and wall mounted sink
  - Installation of replacement flooring, if necessary due to bath modification
- Environmental Control Units − Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.
- Environmental safety devices limited to:
  - Door alarms
  - Anti-scald devices
  - Hand-held shower head
  - Grab bars for the bathroom
- Fence – Limited to 200 linear feet (individual must have a documented history of elopement).
- Ramp – Limited to one per individual primary residence and only when no other accessible ramp exists:
  - In accordance with the ADA or ADAAG, unless this is not in the best interest of the client
  - Portable – Considered for rental property only
  - Permanent
  - Vertical lift – May be considered in lieu of a ramp if there is photographic and written documentation that shows it is not possible for a ramp to be used
- Stair lift – If required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per service plan.
- Single room air conditioners/single room air purifiers – If required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per service plan:
  - There is a documented medical reason for the individual's need to maintain a constant external temperature. The documentation necessary for this equipment includes a prescription from the primary care physician.
  - The room air conditioner size is consistent with the room size (square feet) capacity to be cooled.
- Widen doorway − To allow safe egress:
  - Exterior − Modification limited to one per individual primary residence when no other accessible door exists
  - Interior − Modification of bedroom, bathroom, or kitchen door/doorway as needed to allow for access. (A pocket door may be appropriate when there is insufficient room to allow for the door swing)
- Windows − Replacement of glass with Plexiglas® or other shatterproof material when there is a documented medical/behavioral reason.
- Upon the completion of the modification, painting, wall coverings, doors, trim, flooring and so forth will be matched (to the degree possible) to the previous color/style/design.
- Maintenance − Limited to $500 annually for the repair and service of environmental modifications that have been provided through a HCBS waiver:
  - Requests for service must detail parts cost and labor cost.
  - If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a non-waiver funding source.
- Items requested that are not listed above must be reviewed and decision rendered by the State division director or State agency designee.

## Service Standards

- Environmental Modification must be of direct medical or remedial benefit to the individual.
- Environmental Modifications must meet applicable standards of manufacture, design and installation and should be guided by Americans with Disability Act (ADA) or ADA Accessibility Guidelines (ADAAG) requirements when in the best interest of the individual and his/her specific situation.
- Environmental Modifications must be compliant with applicable building codes.

## Documentation Standards

- The identified direct benefit or need must be documented within:
  - Service plan
  - Physician prescription and/or clinical evaluation as deemed appropriate
- Documentation/explanation of the service within the Request for Approval to Authorize Services (RFA) including the following:
  - Property owner of the residence where the requested modification is proposed
  - Property owner's relationship to the individual
  - What, if any, relationship the property owner has to the waiver program
  - Length of time the individual has lived at this residence
  - If a rental property, length of lease
  - Written agreement of landlord for modification
  - Verification of individual's intent to remain in the setting
  - Land survey may be required when exterior modifications approach property line
- Signed and approved RFA
- Signed and approved service plan
- Provider of services required to maintain receipts for all incurred expenses related to the modification
- Must be in compliance with FSSA and Division-specific guidelines and/or policies

## Limitations

A lifetime cap of $15,000 is available for environmental modifications. The cap represents a cost for basic modification of an individual's home for accessibility and safety and accommodates the individual's needs for housing modifications. The cost of an environmental modification includes all materials, equipment, labor, and permits to complete the project. No parts of an environmental modification may be billed separately as part of any other service category (for example, Specialized Medical Equipment). In addition to the $15,000 lifetime cap, $500 is allowable annually for the repair, replacement, or an adjustment to an existing environmental modification that was funded by a HCBS waiver.

## Activities Not Allowed

Examples/descriptions of activities not allowed include, but are not limited to the following, such as:

- Adaptations or improvements that are not of direct medical or remedial benefit to the individual:
  - Central heating and air conditioning
  - Routine home maintenance
  - Installation of standard (non-ADA or ADAAG) home fixtures (such as sinks, commodes, tub, wall, window and door coverings, and so forth) which replace existing standard (non-ADA or ADAAG) home fixtures
  - Roof repair
  - Structural repair

  - Garage doors
  - Elevators
  - Ceiling track lift systems
  - Driveways, decks, patios, sidewalks, household furnishings
  - Replacement of carpeting and other floor coverings
  - Storage (such as cabinets, shelving, closets), sheds
  - Swimming pools, spas or hot tubs
  - Video monitoring system
  - Adaptive switches or buttons to control devices intended for entertainment, employment, or education
  - Home security systems
- Modifications that create living space or facilities where they did not previously exist (such as installation of a bathroom in a garage/basement, and so forth)
- Modifications that duplicate existing accessibility (such as second accessible bathroom, a second means of egress from home, and so forth)
- Modifications that will add square footage to the home
- Individuals living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) are not eligible to receive this service

> *Note: The responsibility for environmental modifications rests with the facility owner or operator);*

- Individuals living in a provider-owned residence are not eligible to receive this service

> *Note: The responsibility for environmental modifications rests with the facility owner or operator.*

- Completion of, or modifications to, new construction or significant remodeling/reconstruction are excluded unless there is documented evidence of a significant change in the individual's medical or remedial needs that now require the requested modification
- Services to participants receiving Adult Family Care
- Services to participants receiving Assisted Living

## *Provider Qualifications*

Table 7.8 – Provider Qualifications Table for Environmental Modifications

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | FSSA/DA approved Environmental Modification Individual | Any applicable licensure must be in place | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider qualifications: General requirements<br>*455 IAC 2* Maintenance of Records of services provided<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements; documentation of qualifications<br>*455 IAC 2* Warranty required |

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| | | | Compliance with applicable building codes/ permits. |
| A&D, TBI | FSSA/DA approved Environmental Modification Agency/ Contractor | Any applicable licensure<br>*IC 25-20.2*<br>Home inspector<br>*IC 25-28.5*<br>Plumber<br><br>Evaluator<br>*IC 25-23.5*<br><br>Certification<br>IC 25-4<br>Architect | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider qualifications: General requirements<br>*455 IAC 2* Maintenance of Records of services provided<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements; documentation of qualifications<br>*455 IAC 2* Warranty required<br>Compliance with applicable building codes and permits |
| A&D, TBI | Plumber | IC 25-28.5 | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider qualifications: General requirements<br>*455 IAC 2* Financial information<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements; documentation of qualifications<br>*455 IAC 2* Warranty required<br>Compliance with applicable building codes and permits |
| A&D, TBI | Architect | *IC 25-4* | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider qualifications: General requirements<br>*455 IAC 2* Financial information<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements; documentation of qualifications<br>*455 IAC 2* Warranty required<br>Compliance with applicable building codes and permits |

# Health Care Coordination

## *Service Definition*

Health Care Coordination includes medical coordination provided by a registered nurse (RN) to manage the healthcare of the individual including physician consults, medication ordering, and development and nursing oversight of a healthcare support plan. Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act. The purpose of Health Care Coordination is stabilization, delay/prevent deterioration of health status, management of chronic conditions, and/or improved health status. Health Care Coordination is open to any waiver participant whose needs demonstrate the need for such level of service without duplicating other formal and informal supports.

Because of the different benefits provided under Skilled Nursing and Health Care Coordination, Medicaid Prior Authorization for skilled nursing services is not necessary prior to the provision of Health Care Coordination.

The appropriate level of Health Care Coordination service should be determined by a healthcare professional (RN or doctor).

## *Allowable Activities*

- Physician consultations
- Medication ordering
- Development and oversight of a healthcare support plan

## *Service Standards*

- Weekly consultations or reviews
- Face-to-face visits with the individual
- Other activities, as appropriate
- Services must address needs identified in the service plan
- The provider of home health care coordination to provide a written report to pertinent parties at least quarterly
  - Pertinent parties include the individual, guardian, waiver case manager, all service providers, and other entities.

## *Documentation Standards*

- Current Indiana RN license for each nurse
- Evidence of a consultation including complete date and signature; consultation can be with the individual, other staff, other professionals, as well as healthcare professionals
- Evidence of a face-to-face visit with the individual, including complete date and signature

## *Limitations*

Health Care Coordination services will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Health Care Coordination services are:

- A minimum of one face-to-face visit per month
- Not to exceed eight hours of Health Care Coordination per month

### *Activities Not Allowed*

- Skilled nursing services that are available under the Medicaid State plan
- Case management services provided under a 1915(b) managed care waiver, 1915(c) HCBS waiver, or 1915(g) targeted case management waiver
- Services to participants receiving Assisted Living waiver service
- Any other service otherwise provided by the waiver

### *Provider Qualifications*

Table 7.9 – Provider Qualifications Table for Health Care Coordination

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | Licensed Home Health Agency | *IC 16-27-1* Home Health Agency<br>*IC 25-23-1* RN | DA approved |

# Home-Delivered Meals

## *Service Definition*

A home-delivered meal is a nutritionally balanced meal. This service is essential in preventing institutionalization because the absence of nutrition in individuals with frail and disabling conditions presents a severe risk to health. No more than two meals per day will be reimbursed under the waiver.

## *Allowable Activities*

- Provision of meals
- Diet and nutrition counseling provided by a registered dietician
- Nutritional education
- Diet modification according to a physician's order as required meeting the individual's medical and nutritional needs

## *Service Standards*

- Home-delivered meals will be provided to persons who are unable to prepare their own meals and for whom there are no other persons available to do so or where the provision of a home-delivered meal is the most cost effective method of delivering a nutritionally adequate meal.
- All meals must meet state, local, and federal laws and regulations regarding the safe handling of food. The provider must also hold adequate and current Servsafe Certification.
- All meals must also meet the Dietary Reference Intake Standards adopted by the state of Indiana Division of Aging in compliance with the current Dietary Guidelines for Americans produced by the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. Each meal must meet one-third of the current RDA as established by the food and nutrition board of the National Academy of Sciences, National Research Council.

## *Documentation Standards*

- Identified need in the service plan
- Date of service and units of service documented

## *Activities Not Allowed*

- No more than two meals per day to be reimbursed under the waiver
- Services to participants receiving Adult Family Care waiver service
- Services to participants receiving Assisted Living waiver service

## *Provider Qualifications*

Table 7.10 – Provider Qualifications Table for Home Delivered Meals

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | FSSA/DA approved Home Delivered Meals Agency | Not required | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Becoming an approved provider; maintaining approval |

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| | | | *455 IAC 2* Provider qualifications: General requirements<br>*455 IAC 2* Maintenance of Records of services provided<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Maintenance of records of services provided<br><br>Must comply with all State and local health laws and ordinances concerning preparation, handling, and serving of food. |

# Homemaker Services

## *Service Definition*

Homemaker services offer direct and practical assistance consisting of household tasks and related activities. Homemaker services assist the individual to remain in a clean, safe, and healthy home environment. Homemaker services are provided when the individual is unable to meet these needs or when an informal caregiver is unable to meet these needs for the individual.

## *Allowable Activities*

- Provides housekeeping tasks which include:
  - Dusting and straightening furniture
  - Cleaning floors and rugs by wet or dry mop and vacuum sweeping
  - Cleaning the kitchen, including washing dishes, pots, and pans; cleaning the outside of appliances and counters and cupboards; cleaning ovens and defrosting and cleaning refrigerators
  - Maintaining a clean bathroom, including cleaning the tub, shower, sink, toilet bowl, and medicine cabinet; emptying and cleaning commode chair or urinal
  - Laundering clothes in the home or laundromat, including washing, drying, folding, putting away, ironing, and basic mending and repair
  - Changing linen and making beds
  - Washing insides of windows
  - Removing trash from the home
  - Choosing appropriate procedures, equipment, and supplies; improvising when there are limited supplies, keeping equipment clean and in its proper place
  - Clearing primary walk-ways
- Provides assistance with meals or nutrition which includes:
  - Shopping, including planning and putting food away
  - Making meals, including special diets under the supervision of a registered dietitian or health professional
- Runs the following essential errands:
  - Grocery shopping
  - Household supply shopping
  - Prescription pickup
- Provides assistance with correspondence and bill paying

## *Service Standards*

Homemaker services must follow a written service plan addressing specific needs determined by the client's assessment.

## *Documentation Standards*

- Identified need in the service plan
- Date of service and units of service
- Documentation of services delivered

## *Activities Not Allowed*

- Assistance with hands-on services such as eating, bathing, dressing, personal hygiene, and activities of daily living

- Escorting or transporting individuals to community activities or errands
- Homemaker services provided to household members other than to the participant
- Homemaker services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or legal guardian of a participant
- Services to participants receiving Adult Family Care waiver service
- Services to participants receiving Assisted Living waiver service

## *Provider Qualifications*

Table 7.11 – Provider Qualifications Table for Homemaker Services

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | Licensed Personal Services Agency | *IC 16-27-4* | DA approved |
| A&D, TBI | FSSA/DA approved Homemaker Individual | Not required | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Provider qualifications: becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider qualifications: general requirements<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements<br>*455 IAC 2* Personnel Records<br><br>Compliance with *IC 16-27-4*, if applicable. |
| A&D, TBI | Licensed Home Health Agency | *IC 16-27-1*<br>*IC 16-27-4* | DA approved |

# Nutritional Supplements

## *Service Definition*

Nutritional (dietary) supplements include liquid supplements, such as "Boost®" or "Ensure®" to maintain an individual's health in order to remain in the community.

Supplements should be ordered by a physician based on specific life stage, gender, or lifestyle.

Reimbursement for approved Nutritional Supplement expenditures is reimbursed through the local Area Agency on Aging (AAA) that maintains all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid Agency at their election.

## *Allowable Activities*

Enteral Formulae, category 1 such as "Boost" or "Ensure"

## *Service Standards*

- Nutritional Supplement services must be reflected in the cost comparison budget (CCB) of the individual
- Services must address needs identified in the CCB

## *Documentation Standards*

- Identified need in the service plan
- Documentation to support services rendered

## *Limitations*

An annual cap of $1,200 is available for nutritional supplement services.

## *Activities Not Allowed*

- Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service)
- Services to participants receiving Adult Family Care waiver service
- Services to participants receiving Assisted Living waiver service

## *Provider Qualifications*

Table 7.12 – Provider Qualifications Table for Nutritional Supplements

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | FSSA/DA approved Nutritional Supplements Agency | Not required | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider qualifications: General requirements |

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| | | | *455 IAC 2* Transfer of individual's record upon change of provider<br>*455 IAC 2* Maintenance of Records of services provided<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Individual's personal file; site of service delivery |

# Personal Emergency Response System

## *Service Definition*

Personal Emergency Response System (PERS) is an electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's telephone and programmed to signal a response center once a "help" button is activated. The response center is staffed 24 hours daily/ 7 days per week by trained professionals.

## *Allowable Activities*

- PERS limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision
- Device installation service
- Ongoing monthly maintenance of device

## *Service Standards*

Must be included in the individual's service plan

## *Documentation Standards*

- Identified need in the service plan
- Documentation of expense for installation
- Documentation of monthly rental fee

## *Activities Not Allowed*

- The replacement cost of lost or damaged equipment
- Reimbursement is not available for PERS Supports when the individual requires constant supervision to maintain health and safety
- Services to participants receiving Adult Family Care waiver service
- Services to participants receiving Assisted Living waiver service

## *Provider Qualifications*

Table 7.13 – Provider Qualifications Table for Personal Emergency Response System

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | FSSA/DA approved Personal Emergency Response System Agency | Not required | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider qualifications: General requirements<br>*455 IAC 2* Maintenance of Records of services provided<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements; |

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| | | | documentation of qualifications<br>*455 IAC 2* Warranty required<br>Compliance with applicable building codes and permits |

# Pest Control

## *Service Definition*

Pest control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans and/ or annoys humans and is causing or is expected to cause more harm than is reasonable to accept. Pests include insects such as roaches, mosquitoes, and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice.

Services to control pests are services that prevent, suppress, or eradicate pest infestation.

Reimbursement for approved Pest Control expenditures is reimbursed through the local AAA who maintains all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid Agency at their election.

## *Allowable Activities*

- Pest control services are added to the service plan when the case manager determines through direct observation or client report- that a pest is present that is causing or is expected to cause more harm than is reasonable to accept
- Services to control pests are services that , suppress or eradicate pest infestation

## *Service Standards*

Pest control service must be reflected in the individual service plan

## *Documentation Standards*

- Identified need in the service plan
- Receipts of specific service, date of service, and cost of service completed

## *Limitations*

An annual cap of $600 is available for pest control services.

## *Activities Not Allowed*

- Pest control services may not be used solely as a preventative measure, there must be documentation of a need for this service either through care manager direct observation or individual report that a pest is causing or is expected to cause more harm than is reasonable to accept
- Services to participants receiving Adult Family Care waiver service
- Services to participants receiving Assisted Living waiver service

## *Provider Qualifications*

Table 7.14 – Provider Qualifications Table for Pest Control

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | FSSA/DA approved Pest | *IC 15-3-3.6* | DA approval based upon provider compliance with *455 IAC 2* |

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| | Control Agency | | DA approved<br>*455 IAC 2* Becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider qualifications: General requirements<br>*455 IAC 2* Maintenance of Records of services provided<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements; documentation of qualifications<br>*455 IAC 2* Warranty required<br><br>Pesticide applicators must be certified or licensed through the Purdue University Extension Service and the Office of the Indiana State Chemist. |

# Residential-Based Habilitation

## *Service Definition*

Residential-Based Habilitation service provides training to regain skills that were lost secondary to the traumatic brain injury (TBI).

## *Allowable Activities*

Goal oriented training and demonstration with;

- Skills related to activities of daily living:
  - Personal grooming
  - Bed making and household chores
  - Planning meals, the preparation of food
- Skills related to living in the community:
  - Using the telephone
  - Learning to prepare lists and maintaining calendars of essential activities and dates, and other organizational activities to improve memory
  - Handling money and paying bills
  - Shopping and errands
  - Accessing public transportation

## *Service Standards*

Residential Based Habilitation services must follow a written service plan addressing specific measurable goals and objectives to help with the acquisition, retention, or improvement of skills that were lost secondary to the TBI.

Residential Based Habilitation services must be monitored monthly.

## *Documentation Standards*

- Identified need in the service plan
- Services outlined in the service plan
- A data record of services provided, including;
- Complete date and time of service (in and out)
- Specific services/tasks provided
- Monthly documentation of progress toward identified goals
- Signature of employee providing the service (minimally the last name and first initial). If the person providing the service is required to be a professional the title of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.
- Documentation of service delivery is to be signed by the participant or designated participant representative.

## Limitations

Services provided through Residential-Based Habilitation service will not duplicate services provided under the Medicaid State Plan or any other waiver service

## Activities Not Allowed

- Payments for residential based habilitation are not made for room and board
- Payment for residential based habilitation does not include payments made directly or indirectly when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant or the legal guardian of a participant.
- Payments will not be made for routine care and supervision
- Residential Based Habilitation services to participants receiving Adult Family Care waiver service

## Provider Qualifications

Table 7.15 – Provider Qualifications Table for Residential Based Habilitation

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| TBI | FSSA/DA approved Residential Based Habilitation Agency | Not required | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Provider Qualifications; General requirements<br>*455 IAC 2* General requirements for direct care staff<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements<br>*455 IAC 2* Personnel Records<br><br>Habilitation services must be performed by persons who are supervised by a certified brain injury specialist (CBIS) or qualified mental retardation professional (QMRP) or a physical, occupational, or speech therapist licensed by the state of Indiana and have successfully completed training or have experience in conducting habilitation programs. |

# Respite Services

## *Service Definition*

Respite services are those services that are provided temporarily or periodically in the absence of the usual caregiver. Service may be provided in the following locations:

- In an individual's home
- In the private home of the caregiver

The level of professional care provided under respite services depends on the needs of the individual.

- An individual requiring assistance with the following:
  - Bathing
  - Meal preparation and planning
- Specialized feeding, such as an individual who:
  - Has difficulty swallowing
  - Refuses to eat
  - Does not eat enough
  - Dressing or undressing
  - Hair and oral care
  - Weight bearing transfer assistance should be considered for respite home health aide under the supervision of a registered nurse
  - An individual requiring infusion therapy; venipuncture; injection; wound care for surgical, decubitus, incision; ostomy care; and tube feedings should be considered for respite nursing services

## *Allowable Activities*

- Home health aide services
- Skilled nursing services

## *Service Standards*

- The level of care and type of respite will not exceed the requirements of the service plan- therefore, skilled nursing services will only be provided when the needs of the individual warrant skilled care
- If an individual's needs can be met with an LPN, but an RN provides the service, the service may only be billed at the LPN rate
- Respite must be reflected in the service plan

## *Documentation Standards*

- Identified need in the service plan
- Services outlined in the service plan
- Documentation must include the following elements:
  - Reason for the respite
  - Location where the service was rendered
  - Type of respite rendered
- Data Record of staff to individual service documenting the complete date and time in and time out, and the number of units of service delivered that day
- Each staff member providing direct care or supervision of care to the individual makes at least one entry on each day of service describing an issue or circumstance concerning the individual

- Documentation should include date and time, and at least the last name and first initial of the staff person making the entry. If the person providing the service is required to be a professional, the title of the individual must also be included (example: if a nurse is required to perform the service then the RN title would be included with the name)Any significant issues involving the individual requiring intervention by a health care professional, or case manager that involved the individual also needs to be documented

## *Activities Not Allowed*

- Respite shall not be used as day/child care to allow the persons normally providing care to go to work
- Respite shall not be used as day/child care to allow the persons normally providing care to attend school
- Respite shall not be used to provide service to a participant while participant is attending school
- Respite may not be used to replace services that should be provided under the Medicaid State Plan
- Respite will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant
- Respite must not duplicate any other service being provided under the participant's POC
- Services to participants receiving Adult Family Care waiver service
- Services to participants receiving Assisted Living waiver service

## *Provider Qualifications*

Table 7.16 – Provider Qualifications Table for Respite

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | Licensed Home Health Agency | *IC 16-27-1* | DA approved |

# Specialized Medical Equipment and Supplies

## *Service Definition*

Specialized Medical Equipment and Supplies are medically prescribed items required by the individual's service plan, which are necessary to assure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

All Specialized Medical Equipment and Supplies must be approved by the waiver program prior to the service being rendered.

- Individuals requesting authorization for this service through Home and Community Based Services (HCBS) waivers must first exhaust eligibility of the desired equipment or supplies through Indiana Medicaid State Plan, which may require prior authorization (PA).
  - There should be no duplication of services between HCBS waiver and Medicaid State Plan;
  - The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Medicaid State Plan is not a justification for waiver purchase;
  - Preference for a specific brand name is not a medically necessary justification for waiver purchase. Medicaid State Plan often covers like equipment but may not cover the specific brand requested. When this occurs, the individual is limited to the Medicaid State Plan covered service/brand;
  - Reimbursement is limited to the Medicaid State Plan fee schedule, if the requested item is covered under Medicaid State Plan;
  - All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Medicaid State Plan PA request and decision, if requested item is covered under State Plan.
- Specialized Medical Equipment and Supplies shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:
  - The request is the most cost effective or conservative means to meet the individual's specific needs;
  - The request is individualized, specific, and consistent with, but not in excess of, the individual's needs;
- Requests will be denied if the Division of Aging director or designee determines the documentation does not support the service requested.

## *Allowable Activities*

Justification and documentation is required to demonstrate that the request is necessary in order to meet the individual's identified needs.

- Communication Devices − Computer adaptations for keyboard, picture boards, and so forth. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan
- Generators (portable) − When either ventilator, daily use of oxygen via a concentrator, continuous infusion of nutrition (tube feeding), or medication through an electric pump are medical requirements of the individual. The generator is limited to the kilo-wattage necessary to provide power to the essential life-sustaining equipment, and is limited to one generator per individual per 10 year period
- Interpreter service − Provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (for example, waiver case

conferences, team meetings) and is not available to facilitate communication for other service provision

- Self-help devices − Including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses, and eating utensils that are prescribed by a physical therapist or occupational therapist
- Strollers − When needed because individual's primary mobility device does not fit into the individual's vehicle/mode of transportation, or when the individual does not require the full time use of a mobility device, but a stroller is needed to meet the mobility needs of the individual outside of the home setting. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan
- Manual wheelchairs − When required to facilitate safe mobility. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan
- Maintenance − Limited to $500 annually for the repair and service of items that have been provided through a HCBS waiver: Items that were previously purchased through the waiver, but not listed in allowable activities, will continue to be maintained according to the definition.
  - Requests for service must detail parts cost and labor cost;
  - If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.
- Posture chairs and feeding chairs − As prescribed by physician, occupational therapist, or physical therapist. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

## Service Standards

- Specialized Medical Equipment and Supplies must be of direct medical or remedial benefit to the individual;
- All items shall meet applicable standards of manufacture, design and service specifications;

## Documentation Standards

Documentation standards include the following:

- The identified direct benefit or need must be documented within:
  - Service plan; and
  - Physician prescription and/or clinical evaluation as deemed appropriate.
- Medicaid State Plan Prior Authorization request and the decision rendered, if applicable;
- Signed and approved Request for Approval to Authorize Services (RFA);
- Signed and approved service plan;
- Provider of services must maintain receipts for all incurred expenses related to this service;
- Must be in compliance with FSSA and Division specific guidelines and/or policies.

## Limitations

Maintenance − Limited to $500 annually for the repair and service of items that have been provided through a HCBS waiver:

- Requests for service must detail parts cost and labor cost;
- If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

## *Activities Not Allowed*

- The following items and equipment:
  - Hospital beds
  - Air fluidized suspension mattresses/beds
  - Therapy mats
  - Parallel bars
  - Scales
  - Activity streamers
  - Paraffin machines or baths
  - Therapy balls
  - Books
  - Games
  - Toys
  - Electronics such as CD players, radios, cassette players, tape recorders, television, VCR/DVDs, cameras or film, videotapes and other similar items;
  - Computers and software
  - Adaptive switches and buttons
  - Exercise equipment such as treadmills or exercise bikes
  - Furniture
  - Appliances such as refrigerator, stove, hot water heater
  - Indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, play houses, merry-go-rounds
  - Swimming pools, spas, hot tubs, portable whirlpool pumps
  - Tempurpedic-type mattresses, positioning devices, pillows
  - Bathtub lifts
  - Motorized scooters
  - Barrier creams, lotions, personal cleaning cloths
  - Totally enclosed cribs and barred enclosures used for restraint purposes
  - Vehicle modifications
  - Medication dispensers
  - Any equipment or items that can be authorized through Medicaid State Plan
  - Any equipment or items purchased or obtained by the individual, his/her family members, or other non-waiver providers

## *Provider Qualifications*

Table 7.17 – Provider Qualifications Table for Specialized Medical Equipment and Supplies

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | Licensed Home Health Agency | *IC 16-27-1* | DA approved<br>*455 IAC 2* Warranty required |
| A&D, TBI | FSSA/DA approved Specialized Medical Equipment and Supplies Agency | *IC 25-26-21 Certification*<br>*IC 6-2.5-8-1* | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider qualifications: General requirements<br>*455 IAC 2* Maintenance of Records of services provided |

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| | | | *455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements; documentation of qualifications<br>*455 IAC 2* Warranty required |

# Structured Day Program

## *Service Definition*

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a nonresidential setting, separate from the home in which the individual resides. Services shall normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week unless provided as an adjunct to other day activities included in an individual's service plan.

## *Service Standards*

- Structured Day Program services must follow a written service plan addressing specific needs determined by the individual's assessment
- Structured Day Program services shall focus on enabling the individual to attain or maintain his or her functional level
- Structured Day Program service shall be coordinated with any physical, occupational, or speech therapies listed in the service plan
- Structured Day Program services may serve to reinforce skills or lessons taught in school, therapy, or other settings

## *Documentation Standards*

- Identified need in the service plan
- Services outlined in the service plan
- Data record of services provided, including:
  - Complete date and time of service (in and out)
  - Specific services/tasks provided
  - Signature of employee providing the service (minimally the last name and first initial) If the person providing the service is required to be a professional, the title of the individual must also be included.

  Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.

## *Limitations*

> *Note: Services provided through Structured Day Program will not duplicate any service provided under the Medicaid State Plan or other waiver service.*

## *Provider Qualifications*

Table 7.18 – Provider Qualifications Table for Structured Day Program

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| TBI | FSSA/DA approved Structured Day Program Agency | Not required | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Provider Qualifications; General |

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| | | | requirements<br>*455 IAC 2* General requirements for direct care staff<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements<br>*455 IAC 2* Personnel Records<br><br>Habilitation services must be performed by persons who are supervised by a Certified Brain Injury Specialist (CBIS) or Qualified Mental Retardation Professional (QMRP) or a physical, occupational, or speech therapist licensed by the state of Indiana and have successfully completed training or have experience in conducting habilitation programs. |

# Supported Employment

## *Service Definition*

Supported Employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported Employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

## *Service Standards*

- Supported Employment services must follow a written service plan addressing specific needs determined by the individual's assessment
- When Supported Employment services are provided at a worksite where persons without disabilities are employed, payment will only be made for the adaptation, supervision and training required by individuals receiving waiver services as a result of their disabilities and will not include payment for supervisory activities rendered as a normal part of the business setting
- Supported Employment services furnished under the waiver must be services which are not available under a program funded by either the *Rehabilitation Act of 1973* or *P.L. 94-142*. Documentation will be maintained in the file of each individual receiving this service showing that the service is not otherwise available under a program funded under the *Rehabilitation Act of 1973* or *P.L. 94-142*

## *Documentation Standards*

- Identified need in the service plan
- Services outlined in the service plan
- Data record of services provided, including:
  - Complete date and time of service (in and out)
  - Specific services/tasks provided
  - Signature of employee providing the service (minimally the last name and first initial) If the person providing the service is required to be a professional, the title of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.

## *Limitations*

When Supported Employment services are provided at a worksite where persons without disabilities are employed, payment will only be made for the adaptation, supervision and training required by individuals receiving waiver services as a result of their disabilities

## *Activities Not Allowed*

- Services funded under the Rehabilitation Act of 1973 or P.L. 94-142
- Reimbursement for supervisory activities rendered as a normal part of standard business procedures in a business setting where persons without disabilities are also employed
- Reimbursement for incentive payments, subsidies, or unrelated vocational training expenses for the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in a Supported Employment program;
- Payments that are passed through to users of Supported Employment programs; or
- Payments for vocational training that are not directly related to an individual's employment program.

## Provider Qualifications

Table 7.19 – Provider Qualifications Table for Supported Employment

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| TBI | FSSA/DA approved Supported Employment Agency | Certification CARF | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Provider Qualifications; General requirements<br>*455 IAC 2* General requirements for direct care staff<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements<br>*455 IAC 2* Personnel Records |
| TBI | Community Mental Health Center | Not required | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Provider Qualifications; General requirements<br>*455 IAC 2* General requirements for direct care staff<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements<br>*455 IAC 2* Personnel Records<br>*IC 12-7-2-38(1)* Community Mental Health Center |

# Transportation

## *Service Definition*

Services offered in order to enable individuals served under the waiver to gain access to waiver and other community services, activities and resources, specified by the service plan

## *Service Standards*

- This service is offered in addition to medical transportation required under *42 CFR 431.53* and transportation services under the State plan, defined at *42 CFR 440.170(a)* (if applicable), and shall not replace them
- Transportation services under the waiver shall be offered in accordance with an individual's service plan
- Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized

Transportation services are reimbursed at three types of service:

- Level 1 Transportation – The individual does not require mechanical assistance to transfer in and out of the vehicle
- Level 2 Transportation – The individual requires mechanical assistance to transfer into and out of the vehicle
- Adult Day Service Transportation – The individual requires round trip transportation to access adult day services

## *Documentation Standards*

A provider or its agent shall maintain documentation that the provider meets and maintains the requirements for providing services under *460 IAC 1.2*

## *Limitations*

Services provided under Transportation service will not duplicate services provided under the Medicaid State Plan or any other waiver service.

## *Activities Not Allowed*

- May not be used to meet medical transportation needs already available under the Indiana Medicaid State Plan.
- Separate waiver transportation services are not available to participants receiving Adult Family Care services.
- Services to participants receiving Assisted Living waiver service

## *Provider Qualifications*

Table 7.20 – Provider Qualifications Table for Transportation

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | Licensed Home Health Agency | *IC 16-27-1* | DA approved<br>Compliance with applicable vehicle/driver licensure for vehicle being utilized |

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| *A&D, TBI* | *FSSA/DA approved Transportation Agency* | *Not required* | *DA approval based upon provider compliance with 455 IAC 2*<br><br>*DA approved*<br>*455 IAC 2 Becoming an approved provider; maintaining approval*<br>*455 IAC 2 Provider Qualifications: General Requirements*<br>*455 IAC 2 General requirements for direct care staff*<br>*455 IAC 2 Procedures for protecting individuals*<br>*455 IAC 2 Unusual occurrence; reporting*<br>*455 IAC 2 Transfer of individual's record upon change of provider*<br>*455 IAC 2 Notice of termination of services*<br>*455 IAC 2 Provider organizational chart*<br>*455 IAC 2 Collaboration and quality control*<br>*455 IAC 2 Data collection and reporting standards*<br>*455 IAC 2 Quality assurance and quality improvement system*<br>*455 IAC 2 Financial information*<br>*455 IAC 2 Liability insurance*<br>*455 IAC 2 Transportation of an individual*<br>*455 IAC 2 Documentation of qualifications*<br>*455 IAC 2 Maintenance of personnel records*<br>*455 IAC 2 Adoption of personnel policies*<br>*455 IAC 2 Operations manual*<br>*455 IAC 2 Maintenance of records of services provided*<br>*455 IAC 2 Individual's personal file; site of service delivery*<br><br>*Compliance with applicable vehicle/driver licensure* ***for vehicle*** *being utilized* |

# Vehicle Modifications

## *Service Definition*

Vehicle modifications (VMOD) are the addition of adaptive equipment or structural changes to a motor vehicle that permit an individual with a disability to safely transport in a motor vehicle. Vehicle modifications, as specified in the service plan, may be authorized when necessary to increase an individual's ability to function in a home and community based setting to ensure accessibility of the individual with mobility impairments. These services must be necessary to prevent or delay institutionalization. The necessity of such items must be documented in the service plan by a physician's order. Vehicles necessary for an individual to attend post-secondary education or job related services should be referred to Vocational Rehabilitation Services.

The vehicle to be modified must meet all the following:

- The individual or primary caregiver is the titled owner
- The vehicle is registered and/or licensed under state law
- The vehicle has appropriate insurance as required by state law
- The vehicle is the individual's sole or primary means of transportation
- The vehicle is not registered to or titled by a FSSA approved provider

All vehicle modifications must be approved by the waiver program prior to services being rendered.

- Vehicle modification requests must meet and abide by the following:
  - The vehicle modification is based on, and designed to meet, the individual's specific needs
  - Only one vehicle per an individual's household may be modified
  - The vehicle is less than 10 years old and has less than 100,000 miles on the odometer
  - If the vehicle is more than five years old, the individual must provide a signed statement from a qualified mechanic verifying that the vehicle is in sound condition.
- All vehicle modification shall be authorized only when it is determined to be medically necessary and/or shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:
  - The modification is the most cost effective or conservative means to meet the individual's specific needs
  - The modification is individualized, specific, and consistent with, but not in excess of, the individual's needs
  - All bids must be itemized
- Many automobile manufacturers offer a rebate of up to $1,000 for individuals purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the individual is required to submit to the manufacturer documented expenditures of modifications. If the rebate is available it must be applied to the cost of the modifications.
- Requests for modifications may be denied if the Division of Aging director or designee determines the documentation does not support the service requested.

## *Allowable Activities*

Justification and documentation is required to demonstrate that the modification is necessary in order to meet the individual's identified needs.

- Wheelchair lifts;
- Wheelchair tie-downs (if not included with lift);
- Wheelchair/scooter hoist;

- Wheelchair/scooter carrier for roof or back of vehicle;
- Raised roof and raised door openings;
- Power transfer seat base (Excludes mobility base);
- Maintenance is limited to $500 annually for repair and service of items that have been funded through a HCBS waiver:
  - Requests for service must differentiate between parts and labor costs;
  - If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.
- Items requested which are not listed above, must be reviewed and decision rendered by the State division director or State agency designee.

## Service Standards

- Vehicle modification must be of direct medical or remedial benefit to the individual;
- All items must meet applicable manufacturer, design and service standards.

## Documentation Standards

- The identified direct benefit or need must be documented within:
  - Service plan
  - Physician prescription and/or clinical evaluation as deemed appropriate
- Documentation/explanation of service within the Request for Approval to Authorize Services (RFA) must include:
  - Ownership of vehicle to be modified
  - Vehicle owner's relationship to the individual
  - Make, model, mileage, and year of vehicle to be modified
- Signed and approved RFA
- Signed and approved service plan
- Provider of services must maintain receipts for all incurred expenses related to the modification
- Must be in compliance with FSSA and Division specific guidelines and/or policies

## Limitations

A lifetime cap of $15,000 is available for vehicle modifications. In addition to the applicable lifetime cap, $5,000 will be allowable annually for repair, replacement, or an adjustment to an existing modification that was funded by a HCBS waiver.

## Activities Not Allowed

Examples or descriptions of modifications/items not covered include, but are not limited to the following:

- Lowered floor van conversions
- Purchase, installation, or maintenance of CB radios, cellular phones, global positioning/tracking devices, or other mobile communication devices
- Repair or replacement of modified equipment damaged or destroyed in an accident
- Alarm systems
- Auto loan payments
- Insurance coverage

- Driver license, title registration, or license plates
- Emergency road service
- Routine maintenance and repairs related to the vehicle itself
- Services to participants receiving Adult Family Care waiver service
- Services to participants receiving Assisted Living waiver service

## *Provider Qualifications*

Table 7.21 – Provider Qualifications Table for Vehicle Modifications

| Waiver | Provider | Licensure/ Certification | Other Standard |
|---|---|---|---|
| A&D, TBI | FSSA/DA approved Vehicle Modification Agency | Not required | DA approval based upon provider compliance with *455 IAC 2*<br><br>DA approved<br>*455 IAC 2* Becoming an approved provider; maintaining approval<br>*455 IAC 2* Provider qualifications: General requirements<br>*455 IAC 2* Liability insurance<br>*455 IAC 2* Professional qualifications and requirements; documentation of qualifications<br>*455 IAC 2* Maintenance of records of services provided<br>*455 IAC 2* Warranty required |

# *Section 8: Provider Help*

## INsite Communication Instructions

The following are the steps to obtain communications from INsite.

1. From the main screen, click **Release Notes**.
2. Click **Manuals > Bulletins > Procedures**.
3. Choose the manual to view, look at the entire table of contents (double-click on the manual title), index, or perform a search.
4. Contact the INsite Helpdesk at Insite.helpdesk@fssa.in.gov if additional assistance is needed.

## Helpful Websites

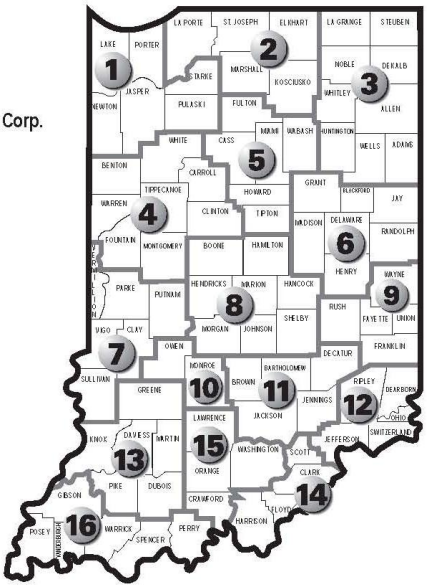
- www.in.gov/fssa – Find information by type of person in need: children, seniors, families, DD, and so forth. All programs and services available are listed on this site.
- http://www.in.gov/fssa/2329.htm – Find the Division of Aging programs and services and information and resources.
- **https://ddrsprovider.fssa.in.gov/IFUR/** – Submit initial incident reports and case manager follow-up reports for waiver and Money Follows the Person (MFP) services.
- www.indianamedicaid.com – Find IHCP provider bulletins, monthly provider newsletters, and the *IHCP Provider Manual*. Telephone contact information for providers is also available on this website.

## Helpful Contact Numbers

- The Division of Aging at 1-888-673-0002
- The Division of Aging waiver provider relations specialist at (317) 234-0373

# Area Agency on Aging Offices

## 16 Area Agencies




**AREA 1**
**Area 1 Agency on Aging**
**Northwest Indiana Community Action Corp.**
5518 Calumet Ave.
Hammond, IN 46320
(219) 937-3500 or (800) 826-7871
FAX (219) 932-0560 or (219) 931-5501
Web Site: www.nwi-ca.org

**AREA 2**
**REAL Services, Inc.**
1151 S. Michigan St., P.O. Box 1835
South Bend, IN 46634-1835
(574) 233-8205 or (800) 552-2916
FAX (574) 284-2642
Web Site: www.realservices.com

**AREA 3**
**Aging and In-Home Services of Northeast Indiana, Inc.**
2729 Lake Avenue
Fort Wayne, IN 46805-5414
(260) 745-1200 or (800) 552-3662
FAX (260) 456-1066
Web Site: www.agingihs.org

**AREA 4**
**Area IV Agency on Aging & Community Action Programs, Inc.**
660 North 36th St., P.O. Box 4727
Lafayette, IN 47903-4727
(765) 447-7683 or (800) 382-7556
TDD (765) 447-3307; FAX (765) 447-6862
Web Site: www.areaivagency.org

**AREA 5**
**Area Five Agency on Aging & Community Services, Inc.**
1801 Smith Street, Suite 300
Logansport, IN 46947-1577
(574) 722-4451 or (800) 654-9421
FAX (574) 722-3447
Web Site: www.areafive.com

**AREA 6**
**LifeStream Services, Inc.**
1701 Pilgrim Blvd., P.O. Box 308
Yorktown, IN 47396-0308
(765) 759-1121 or (800) 589-1121
TDD (800) 589-1121; FAX (765) 759-0060
Web Site: www.lifestreaminc.org

**AREA 7**
**Area 7 Agency on Aging and Disabled**
**West Central Indiana Economic Development District, Inc.**
1718 Wabash Ave., P.O. Box 359
Terre Haute, IN 47803-0359
(812) 238-1561 or (800) 489-1561
TDD (800)489-1561; FAX (812) 238-1564

**AREA 8**
**CICOA In-Home Solutions**
4755 Kingsway Dr., Suite 200
Indianapolis, IN 46205-1560
(317) 254-5465 or (800) 489-9550
FAX (317) 254-5494; TDD (317) 254-5497
Web Site: www.cicoa.org

**AREA 9**
**Area 9 In-Home & Community Services Agency**
520 South 9th St., Suite 100
Richmond, IN 47374-6230
(765) 966-1795, (765) 973-8334 or
(800) 458-9345
FAX (765) 962-1190
Web Site: www.iue.indiana.edu/departments/Area 9

**AREA 10**
**Area 10 Agency on Aging**
7500 W. Reeves Road
Bloomington, IN 47404
(812) 876-3383 or (800) 844-1010
FAX (812) 876-9922
Web Site: www.area10.bloomington.in.us

**AREA 11**
**Aging & Community Services of South Central Indiana, Inc.**
1531 13th Street, Suite G-900
Columbus, IN 47201-1302
(812) 372-6918 or (866) 644-6407
FAX (812) 372-7846l

**AREA 12**
**LifeTime Resources, Inc.**
**13091 Benedict Drive**
Dillsboro, IN 47018
(812) 432-5215 or (800) 742-5001
FAX (812) 432-3822
Web Site: www.lifetime-resources.org

**AREA 13**
**Generations**
**Vincennes University Statewide Services**
P.O. Box 314
Vincennes, IN 47591
(812) 888-4292 or (800) 742-9002
TDD (812) 888-5762; FAX (812) 888-4566
Web Site: www.generationsnetwork.org

**AREA 14**
**LifeSpan Resources, Inc.**
P.O. Box 995, 426 Bank Street
New Albany, IN 47151-0995
(812) 948-8330; FAX (812) 948-0147
lWeb Site: www.lsr14.org

**AREA 15**
**Hoosier Uplands/Area 15 Agency on Aging and Disability Services**
521 West Main Street
Mitchell, IN 47446
(812) 849-4457 or (800) 333-2451
TDD (800) 743-3333; FAX (812) 849-4467
Web Site: www.hoosieruplands.org

**AREA 16**
**Southwestern Indiana Regional Council on Aging, Inc.**
16 W. Virginia St., P.O. Box 3938
Evansville, IN 47737-3938
(812) 464-7800 or (800) 253-2188
FAX (812) 464-7843 or (812) 464-7811
Web Site: www.swirca.org

**To contact your local Area Agency toll-free, call**
**1-800-986-3505**

# Communications

## *General Information*

The Indiana Health Coverage Programs (IHCP) publishes the following communications to providers by mail and posting to indianamedicaid.com:

- IHCP provider bulletins
- IHCP banner pages (published each week)
- IHCP monthly newsletters

Providers may also subscribe to the Email Notification Service at indianamedicaid.com. This service sends an email to subscribers when new communications are posted on indianamedicaid.com.

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